Utah State Hospital Policies and Procedures
Infection Control

The Infection Control Plan outlines activities designed to identify and reduce the risk of endemic and epidemic nosocomial infections in patients and health care workers.
The Infection Control Coordinator, in conjunction with the Infection Control Committee, is responsible for the following:

1. Monitoring physical environment for potential health risks and recommending appropriate interventions.
    - 1.1 Cleanliness of patient care areas;
    - 1.2 Cleanliness of food preparation areas; and,
    - 1.3 Appropriate disposal of waste.
2. Monitoring and supporting appropriate use of Standard Precautions.
    - 2.1 Coordinating new employee and mandatory staff education of Infection Control practices;
    - 2.2 Addressing unit specific concerns, as appropriate; and,
    - 2.3 Addressing staff specific concerns, as appropriate.
3. Monitoring and maintaining records of employee health evaluations.
    - 3.1 Initial employment health screening for chronic or acute health problems which may increase risk of infection for patients or staff;
    - 3.2 Annual evaluation of PPD status; and,
    - 3.3 Evaluation of immunization status with provision of immunizations as indicated for:
        - 3.3.1 MMR (measles, mumps, rubella);
        - 3.3.2 Td (tetanus, diphtheria);
        - 3.3.3 Hepatitis A;
            - 3.3.3.1 Currently offered only to plumbers.
        - 3.3.4 Hepatitis B;
        - 3.3.5 Influenza.
4. Monitoring and educating staff of the importance of work restrictions when direct care staff have potentially infectious conditions including, but not limited to, the following:
    - 4.1 Conjunctivitis;

4.2 Weeping skin lesions;

4.3 Symptomatic diarrhea;

4.4 Mite infestations; and,

4.5 Acute viral or bacterial illnesses.

5. Identifying and reporting selected disease as required by law: Communicable Disease Rule R386-702.

6. Educating staff about Infection Control concerns.

6.1 Writing articles for the *30 Day Review,* as indicated.

6.2 Coordinating new employee and mandatory training on Infection Control.

6.3 Providing unit specific education, as indicated.

7. Identifying and monitoring nosocomial infections.

7.1 Surveying demographically and epidemiologically important infections, as identified by the Infection Control Committee;

7.2 Monitoring anti-infective usage;

7.3 Monitoring infectious processes, as reported by staff; and,

7.4 Identifying clusters or outbreaks of infectious processes.

8. Responding to high-risk, clustered, or unusual infections, as appropriate.

8.1 Evaluating conditions contributing to areas of concern;

8.2 Recommending appropriate interventions; and,

8.3 Reporting to Administrative Staff, as appropriate.

9. The annual evaluation of the Infection Control Plan includes evaluation of:

9.1 <u>SCOPE:</u>

9.1.1 The Infection Control Plan identifies and reduces the risk of endemic and epidemic nosocomial infections in patients and health care workers.

9.2 <u>OBJECTIVES:</u>

9.2.1 Identify and report epidemiologically and demographically important infections;

9.2.2 Respond to significant events;

9.2.3 Maintain adequate staff health screening (i.e. PPD monitoring and health screens);

9.2.4 Provide adequate education for the prevention/control of infections (i.e. work restrictions, Standard Precautions and Blood/Body Fluid Exposure Plan); and,

9.2.5 Provide support for the prevention of infections (i.e. immunizations and education).

9.3 PERFORMANCE:

9.3.1 Hospital-wide infection rate will be <8 per 1000 patient days;

9.3.1.1 Rates in excess of parameter are evaluated;

9.3.1.2 Plan of action is initiated.

9.3.2 Staff will use Standard Precautions.

9.4. EFFECTIVENESS:

9.4.1 Infection Control concerns will be identified and addressed in a timely and appropriate manner (i.e. education and recommendations for change).

Proposed: 11/98
Implemented: 11/98
Revised: 08/99
Revised: 11/00
Reviewed: 01/02
Revised: 02/03
Revised: 08/03
Reviewed : 06/04

Policy

There is an active hospital-wide infection control program.

Procedure

1. Measures have been developed to identify and to control infections acquired at the Utah State Hospital or brought from the community to the hospital.

2. The infection control program includes the following:

2.1 Definitions of nosocomial and community-based infections to provide early identification and reporting of infections and to determine rates of infection.

2.1.1 Nosocomial infections are defined as infections which:

2.1.1.1 are not present or incubating on admission (occurring within 4 days of admission); and/or,

2.1.1.2 are temporally associated with admission to the hospital or a procedure completed at the hospital.

2.1.2 Community-based infections are defined as infections which:

2.1.2.1 are present on admission; and/or,

2.1.2.2 are incubating at the time of admission (occurring within 4 days of admission) and are NOT related to performance of a procedure during an admission at the same facility.

2.2 A system of reporting, evaluating, and maintaining records of infections among patients and personnel. This system includes assignment of responsibility for the ongoing collection of and analytic review of data and follow-up.

2.3 An ongoing review of aseptic, isolation, and sanitation techniques employed in the hospital.

2.4 Written policies defining disease-specific isolation requirements Transmission based precautions and Standard Precautions without compromising the nursing care of potentially infectious or isolated patients.

2.5 Support of infection control procedures relating to the hospital environment, including sterilization, disinfection practices, sterile supply, housekeeping, laundry, physical plant, food services, and waste management.

2.6 Definition of the scope and content of the employee health program.

2.7 Input into the orientation of new employees regarding infection control, hygiene, and definition of each person's responsibility of the overall infection control program.

2.8 Coordination with the medical staff, relative to the clinical use of drugs, through the Chairperson of the Infection Control Committee, who is a member of the Integrated Medical Staff.

3. The infection control program includes other elements which reflect the needs of the hospital. These elements include but are not limited to the following:

3.1 The Infection Control Committee, specifically the Director of Medical Services, who is a member of the Infection Control Committee, may alter traffic patterns on treatment units and set limitations or restrictions on visitors based on a patient's physical condition.

3.2 Forms used for the collection of data related to the infection control program are developed and revised as needed.

3.3 The Infection Control Committee approves and reviews the results of all studies related to infection control.

3.4 Antibiotic susceptibility/resistance trends are reviewed as appropriate by the Infection Control Committee.

3.5 Review of infection control practices and procedures (i.e. cleaning policies and procedures) used throughout the hospital, as

appropriate.

3.6 Quality Resources forwards to the Infection Control Coordinator concerns related to infection control that are identified through patient care monitoring activities. These concerns are addressed by the Infection Control Committee as needed.

3.7 Undiagnosed antemortem infections noted at the time of a Death Review are reported to the Infection Control Committee by the Director of Medical Services with appropriate follow-up as necessary.

3.8 Hospital disposal systems are evaluated by the appropriate authority.

3.9 Ventilation patterns and air exchange rates are appropriate in Sterile Supply, and isolation is appropriate for the hospital. When either a positive or negative pressure isolation system is required for specific airborne diseases as for protective isolation, the identified patient is transported to an appropriate contract facility.

4. Policies and procedures pertaining to infection control are reviewed at least annually by the Infection Control Committee.

5. There are written policies and procedures for all services throughout the hospital.

5.1 Written policies and procedures for patient care areas, services, and departments are reviewed by each area and revised as necessary.

5.2 Infection Control provides support and acts as a resource, in the development of policies and procedures, for services and departments; including, but not limited to:

5.2.1 The nursing service, including patient-care units;

5.2.2 Dietary Department, including Canteen, cafeterias, and vending machines;

5.2.3 Clinics, including dental, optometry, neurology, and podiatry;

5.2.4 Pharmacy services, specifically relating to admixture, drug reconstitution, and the manufacture of intravenous and irrigating fluids;

5.2.6 Radiology services; and,

5.2.7 Support Services, including sterile supply, housekeeping, laundry, beauty shop, swimming pool, physical plant, and recreation.

5.3 Common procedures which have a known association with nosocomial infections include: insertion and care of an IV, urinary catheters, oxygen and suction equipment and care of tracheostomies. Staff completing procedures are advised to carefully follow procedures as outlined in the accepted nursing procedures manual

and to seek assistance as questions arise.

Implemented: 5-16-89
Reviewed: 11-90
Reviewed: 6-92
Reviewed: 9-95
Revised: 5-98
Revised: 12-1998
Revised: 7-1999
Reviewed: 8-1999
Revised: 11/00
Reviewed: 01/02,
Reviewed 08/03
Revised: 06/04

---

1. Identified infections are evaluated and classified as nosocomial or community-based.

    1.1 Nosocomial infections are defined as infections which:

        1.1.1 are not present or incubating on admission (occurring within 4 days of admission); and/or,

        1.1.2 are temporally associated with admission to the hospital or a procedure completed at the hospital; and finally,

        1.1.3 colonization of an organism does *not necessarily* indicate an infectious state.

            1.1.3.1 colonization in a sample indicates that some organisms are reproducing, but that there are no overt symptoms of infection;

            1.1.3.2 colonization of organisms, independent of overt symptoms of infection, does not automatically result in treatment.

                1.1.3.2.1 examples of situations where colonization does not automatically result in treatment include: persons with long-term indwelling catheters or those who perform self-catheterization.

    1.2 Community-based infections are defined as infections which:

        1.2.1 are present on admission; and/or,

        1.2.2 are incubating at the time of admission (occurring within 4 days of admission) and are NOT related to performance of a procedure during an admission at the same facility.

2. Infections classified as nosocomial are statistically significant for hospital infection rates. These infections are diagnosed and treated based on

symptoms and/or culture results. They are reported to the Infection Control Committee under the following general categories:

2.1 Respiratory: Throat, sinus, bronchi/lung, ear and eye infections.

2.2 Genitourinary: Urinary tract and vaginal infections.

2.3 Gastrointestinal: Dental, esophageal, stomach and intestinal infections.

2.4 Skin/Wound: Rashes, wounds/lesions, cellulitis, and tinea.

2.5 Milieu Infection: Occurs in the patient populations after admission as a result of patient behavior.

3. All infections, regardless of nosocomial or community-based classification, are significant. Infections are monitored for clinical significance and/or infectious potential.

Implemented: 7-1998
Revised: 7-1999
Reviewed: 8-1999
Revised: 11/00
Revised: 04/01
Revised: 01/02
Reviewed 08/03
Reviewed: 06/04

The Infectious Process

1. The infectious process relies on a series of inter-connecting events/conditions which lead to infection. There must be a causative agent, a reservoir, a portal of exit, a mode of transmission, a portal of entry and a susceptible host. These are further defined as:

1.1 Causative agent: A biological, physical or chemical entity capable of causing disease. (i.e.-bacteria, virus, fungus etc.)

1.2 Reservoir: Any place where an infective agent can survive and may or may not multiply.

1.3 Portal of Exit: The path by which the infective agent leaves the reservoir.

1.4 Mode of transmission: The mechanism for the successful transfer of an organism or agent from the portal fo a new susceptible host.

1.4.1 Direct contact: Person to person with physical contact.

1.4.2 Indirect contact: A person comes in contact with a contaminated object.

1.5 Portal of entry: The path by which the infective agent enters a susceptible host.

1.6 Susceptible host: A person or animal lacking effective resistance to a pathogenic agent when introduced through a portal. The host then becomes ill and/or forms a reservoir for the pathogen.

Breaking the Infectious Chain

1. To control infections, there must be an intervention which "breaks the chain" of infection.

2. Several interventions are possible to "break" or control this process. They include eliminating or minimizing any component of the process, through:

   2.1 The causative agent: immunizations, good housekeeping, water purification, sterilization and disinfection techniques, good handwashing and use of sterile technique.

   2.2 The reservoir: immunizations, Standard Precautions, water purification, sewage treatment, good health practices and good housekeeping.

   2.3 The portal of exit: Standard Precautions, safer sex practices, good health practices (i.e.-covering nose and mouth when coughing/sneezing-then washing hands).

   2.4 The mode of transmission: Standard Precautions, good handwashing technique, good personal hygiene, good housekeeping.

   2.5 The portal of entry: Standard Precautions, handwashing, good housekeeping, use of sterile technique, use of engineered safety devices e.g. safety syringes.

   2.6 Susceptibility: good health practices,hand washing, immunizations, use of good judgement based on sound information when associating with others.

Implemented: 1984
Revised: 12-1998
Reviewed: 8-1999
Revised: 11/00
Revised: 01/02
Reviewed 08/03
Revised: 06/04

The responsibility of monitoring the infection control program is vested in a multi-disciplinary committee.

1. Determines the type of surveillance and reporting programs to be used in the hospital.

2. Reports nosocomial infections; including respiratory, gastro-intestinal, skin/wound, genitourinary, milieu and others. Recording of data includes, at a minimum, the following:

   2.1 hospital-wide statistics, including types of infections;

2.2 unit statistics, including most common infections;

2.3 laboratory testing, including Hepatitis panels, HIV, and cultures;

2.4 case evaluation of high-risk or unusual infections; and,

2.5 reportable infectious processes.

3. Recommends actions based on information obtained and infection control principles.

4. There is a full-time Infection Control Coordinator, a registered nurse, employed to do surveillance. The Infection Control Coordinator, in addition to collecting required data and routinely carrying out surveillance, is also involved in the following:

4.1 identifying and investigating clusters of infections;

4.2 investigating single cases of unusual nosocomial infections;

4.3 developing and implementing methods to improve patient care procedures;

4.4 developing employee health programs and in-service education on infection control;

4.5 reporting required cases to the Public Health Department; and,

4.6 identifying nosocomial infections post discharge when possible.

5. Infection data originates from the nursing care unit, in one or more of the following ways:

5.1 The physician or nurse practitioner writing the order identifies the infectious process in the written order;

5.2 The registered nurse receiving the order verifies the suspected infectious process in the order;

5.3 The registered nurse notifies Infection Control via E-mail or phone message of new anti-infectives ordered, or newly identified infectious processes;

5.4 Nursing administration,Medical services staff, shift-supervisors or other interested staff report any patterns, trends or concerns relating to infection control.

5.5 The Infection Control Coordinator identifies areas of concern based on direct observation or informal reports from staff.

6. The data are evaluated by the Infection Control Coordinator.

6.1 The Infection Control Coordinator consults with the Director of Medical Services when warranted by the situation.

6.2 Authority is delegated by the Director of Medical Services to the

Infection Control Coordinator or to unit registered nurse practitioners or unit registered nurses to:

6.2.1 report any actual or suspected infection; and,

6.2.3 initiate appropriate isolation procedures.

6.3 When any of these actions are taken, the appropriate medical staff member responsible for the patient's care is notified.

7. The Infection Control Committee reviews infections in the hospital with regard to proper management and epidemic potential.

7.1 The Infection Control Committee determines the presence of nosocomial infections and recommends actions to minimize such.

7.2 Review may be directed to surveillance data when available, looking for unusual epidemic, clusters, infections due to unusual pathogens, or any occurrence of nosocomial infections that exceed the acceptable levels.

7.2.1 The Infection Control Committee has determined that a case rate of 8 per 1000 patient days is the maximum acceptable level for the hospital.

8. The Infection Control Committee reviews the results of any cultures required by any state, federal, or local agency.

8.1 Sampling is usually reserved for specific situations when the outcome can be expected to have a potential beneficial effect on the standards of care or to support change in maintenance or personnel practices.

8.2 Occasional sampling may be used as a quality control mechanism or as an educational exercise.

9. The Infection Control Committee reviews antimicrobial susceptibility/resistance data.

10. Proposals and protocols for all special infection control studies conducted and results of such studies are reviewed.

11. The committee reviews guidelines and recommendations from various sources (i.e. OSHA) and makes recommendations for the hospital.

12. Pertinent related findings of other committees are reviewed and discussed.

13. Pertinent findings are incorporated into the in-service education and orientation programs.

1. Authority of the Infection Control Committee is approved in writing by the hospital administration and the medical staff.

2. Membership includes representation from medical staff, administration, nursing services, pharmacy, risk management, support services, and other representation as needed. An effort is made to include a member of

the State Health Department on at least a consultative basis.

3. The Infection Control Coordinator is a registered nurse and serves as Infection Control Committee Manager.

4. The Chairman of the Infection Control Committee is a physician with interest and experience in infection control. The Chairman must be present in Infection Control Committee meetings in order for clinical decisions or policy changes to be made.

5. Meetings are held monthly and as necessary.

6. Minutes are recorded of each meeting and are circulated to each member of the committee and the Nursing Administrator.

7. The Infection Control Committee reports its findings and recommendations to medical staff, the Hospital Superintendent, and the Nursing Administrator *via* appropriate committee representatives and through copies of minutes.

8. The Infection Control Committee Manager maintains a file of monthly Infection Control Reports.

Implemented: 3-09-83
Revised: 10-23-85
Revised: 5-16-89
Reviewed: 12-90
Reviewed: 2-93
Revised: 9-95
Revised: 6-98
Revised: 12-1998
Reviewed: 8-1999
Revised: 11/00
Revised: 01/0,
Revised 08/03
Reviewed: 06/04

Policy

All patients admitted to the Utah State Hospital are on Standard Precautions for the duration of their stay.

Procedure

1. All Utah State Hospital employees routinely use appropriate precautions to prevent skin and mucous membrane exposure when contact with blood and other body fluids of any patient is anticipated.

    1.1 Gloves are worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients; for handling items or surfaces soiled with blood or body fluids; and for performing

venipunctures or performance of any procedure where it can be anticipated that blood or other body fluids will be evident i.e. SQ, IM, or ID injections.

1.2 Gloves are discarded after contact with each patient.

1.3 Masks and protective eye wear or face shields are worn during procedures or patient care when droplets of blood or other body fluids are likely to be generated to prevent exposure of mucous membranes of the mouth, nose, and eyes.

1.4 Gowns or aprons are worn during procedures or patient care when splashes of blood or other body fluids are likely to occur.

1.5 Hypo-allergenic gloves, glove liners, or powderless gloves are available to those employees who are allergic to the normally provided gloves.

1.6 Personal protective equipment is considered appropriate only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time the protective wear is used.

1.7 If a piece of clothing or protective wear is penetrated by blood or other potentially infectious materials, the item(s) are removed immediately or as soon as possible.

1.7.1 Personal clothing which is contaminated by blood or other potentially infectious materials is laundered as per the guidelines in the Exposure Control Plan.

1.8 All protective equipment is removed prior to leaving the work area and is placed in the designated area or container for storage, washing, or disposal.

2. Hands and other skin surfaces are washed immediately and thoroughly if contaminated with blood or other body fluids. Hands are washed immediately after gloves are removed.

3. To prevent needle stick injuries, needles are not recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. Used disposable syringes and needles, scalpel blades, and other sharp items are placed in puncture-resistant containers located as close as practical to the use area.

3.1 Syringes with built in safety devices are available for use from Central Supply.

4. Pocket masks and Ambu bags are available in patient-care areas where the need for resuscitation is possible.

5. Employees who have exudative lesions or weeping dermatitis do not do

direct patient care nor handle patient-care equipment until the condition resolves.

6. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses by employees are prohibited in work areas where there is reasonable likelihood of occupational exposure, *i.e.*, medical treatment rooms, laundry, sterile supply, patient rooms, utility rooms, medication rooms.

7. Food and drink are not kept in refrigerators, freezers, or cabinets or on shelves, countertops or bench tops where blood or other potentially infectious materials are present.

8. Guidelines from the Center for Disease Control are used to determine rationale and actions appropriate to each situation.

Implemented: 6-92
Reviewed: 9-95
Revised: 5-98
Revised: 12-1998
Reviewed: 8-1999
Revised: 11/00
Revised: 4/01
Revised: 01/02
Reviewed 08/03
Reviewed: 06/04

Policy

Employees are not allowed to bring their household pets onto the hospital grounds.

Opportunities are provided for any patient of Utah State Hospital to interact with animals through use of a volunteer group. Units may request pet therapy through the Volunteer Coordinator. Units may also request a unit pet for therapeutic reasons through the Unit Clinical Director and the Hospital Clinical Director. Any other request must be made to the Hospital Clinical Director.

Procedure

1. Request for unit pet.

    1.1 Upon approval by the Unit Clinical Director, a unit may request permission from the Hospital Clinical Director to obtain a pet for the treatment unit.

    1.2 The request must include: a statement of unit philosophy regarding pets, the therapeutic intent of having a pet, written procedures for care, feeding, and housing of the pet, maintenance plan of the pet's health, and storage of the pet's food and supplies.

        1.2.1 A copy of the request is sent to the Infection Control Coordinator.

    1.3 The Hospital Clinical Director may approve the request immediately or refer the request to the Infection Control Committee

        1.3.1 The Infection Control Committee responds to the requesting unit within one week.

2. Unit Pets.

    2.1 No exotic pets, such as lizards, snakes, birds, or amphibians of any kind will be allowed on the units.

    2.2 Fish must be maintained in well-kept tanks.

    2.3 Unit pets are allowed under the following conditions:

        2.3.1 Pets are certified clean and disease-free by a licensed veterinarian and have documentation of current immunizations including, but not limited to rabies and distemper.

        2.3.2 Pets are properly licensed.

        2.3.3 Pets are clean and odor-free.

        2.3.4 When pets are not confined, they are under leash or have

completed obedience training to render them controllable at all times.

2.4 Pets are not allowed in areas where their presence creates a significant risk to patients or staff, i.e., food preparation or food serving areas, medication preparation areas, clinics, pharmacy, patients or staff with allergic conditions, etc.

3. Pet Therapy

3.1 Units may request pet therapy through the Volunteer Coordinator.

3.1.1 A volunteer group provides animals to be used in therapy. These animals are highly-trained and responsive to the emotional needs of the patients, and they provide an opportunity for petting and hugging.

3.1.2 All animals used in pet therapy are veterinarian-certified and obedience-trained.

4. Pet Monitoring

4.1 The Infection Control Coordinator maintains a list of all current pets.

5. No pets of employees are allowed on hospital grounds.

6. Family members of a patient may arrange with the treatment coordinator, in advance, to bring the patient's pet to visit with the patient on grounds.

6.1 The pet is not allowed on the unit.

Implemented: 9-86
Revised: 8-88
Revised: 3-92
Reviewed: 9-95
Revised: 10-96
Revised: 5-98
Reviewed: 8-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed 08/03
Reviewed: 06/04

Policy

The laundry service is provided by an outside provider.

Procedure

1. The laundry supervisor is responsible to the Superintendent through the Director of Support Services through the Assistant Superintendent.

2. The supervisor is qualified by training and experience.

3. There is an adequate supply of clean linen that is handled and stored to minimize contamination from surface contact or airborne deposition.

4. Soiled linen is collected as to reduce microbial dissemination into the environment.

    4.1 ALL used linen is considered contaminated.

        a. Unit personnel place all soiled linens in waterproof laundry bags

        b. Linens are handled as little as possible to prevent release of organisms into the air.

        c. If linen is saturated with blood it may be placed into a regular plastic bag or a plastic yellow (NEVER RED) bag if available. This is for the sole purpose that the blood does not ruin/stain other linen. It does not change the decontamination process of soiled laundry.

        d. All laundry bags are tied or closed completely when full

        e. All soiled linens (in the laundry bags) are placed in the designated soiled linen area

    4.2 All laundry employees are required to wear an apron/smock and gloves while in contact with soiled linen and the soiled laundry bags.

    4.3 Germicidal hand cleaners are provided for washing hands immediately after contact.

5. Separate containers are used to transport clean and soiled linen.

6. A quaternary disinfectant and spray tank is used to sanitize the soiled and clean laundry baskets/carts.

7. The Utah State Developmental Center has contracted to wash, dry and fold Utah State Hospital's linen.

    7.1 Soiled linen is picked up and clean linen delivered by USDC every Monday, Wednesday and Friday.

    7.2 When USH receives clean linen from USDC it is packaged and protected from contamination.

8. All laundry personnel are properly trained and competent in USH laundry policies and procedures.

9. Each unit is responsible to ensure the patient's personal soiled laundry is properly stored.

    9.1 Home-type laundry facilities on the units are located away from clean linen storage, food preparation areas, and areas in which clean materials and equipment are stored.

9.2. All patient personal laundry is properly vented in order to prevent any dissemination of contaminants

---

Implemented: 5-22-89
Reviewed: 11-90
Reviewed: 6-92
Reviewed: 9-95
Revised: 5-98
Revised: 8-1999
Revised: 11/00
Reviewed: 01/02
Revised 08/03
Revised: 06/04

Policy

The policy for admission of patients to the Utah State Hospital who are within any of the four groups of the CDC classification of HIV infections is the same as all other admissions to the hospital. Patients with "exceptional" medical problems, requiring physical care beyond capability of the Utah State Hospital, may not be eligible for admission. This restriction includes patients with highly contagious infections or diseases that would normally require isolation facilities and highly technical treatment modalities unavailable at this hospital.

Procedure

1. The Director of Medical Services conducts an individualized review of each case and determines, in collaboration with the Hospital Clinical Director and the Director of Nursing Services, when a patient should not be admitted because of medical problems and/or because of limited nursing resources to care for the patient. The review includes:

    1.1 review of current psychiatric condition of patient;

    1.2 review of current medical and nursing needs of patient; and

    1.3 determination of best treatment facility for patient using guidelines, policies, and information available from the Utah State Hospital, the Utah State Board of Mental Health, and other appropriate agencies.

2. If the patient is admitted, contingency agreements for treatment of the patient are made.

3. Discharge planning is addressed at the time of the individualized review of each prospective patient; discharge is activated upon the successful treatment of the psychiatric disorder or resolution or remission of the problem.

Implemented: 11-91
Reviewed: 6-92
Reviewed: 5-95|
Revised: 11-98
Reviewed: 8-1999
Reviewed: 11/00
Reviewed: 01/02
Revised 08/03
Reviewed: 06/04

Policy

Mandatory HIV testing of patients is prohibited at Utah State Hospital. HIV voluntary testing may be done when medically indicated and when the patient is informed, counselled, and a consent obtained.

Procedure

1. Upon admission, the patient is assessed for a history of high risk behavior (including but not limited to: a history of sexually transmitted disease, IV drug abuse, homosexual intercourse without condoms, blood transfusions before 1985).
2. Upon admission the patient is assessed for clinical signs and symptoms of possible HIV infection, such as persistent fever, persistent cough, shortness of breath, persistent diarrhea, increased fatigue, slow-healing sores, unexplained weight loss, recurrent infections.
3. When a patient presents with a significant history of high risk behavior and/or presents with clinical symptomatology, the physician/nurse practitioner may order an HIV test.
4. Before the HIV test can be performed, the patient or guardian must be given pre-test counselling which includes, but is not limited to: information on HIV transmission and prevention, the benefits of being tested, the psychological and emotional aspects of the test, the HIV antibody test and procedure, disclosure and discrimination.
5. The patient or guardian must sign an informed consent form after the pre-test counseling before the HIV test can be conducted. The patient has the right to refuse testing or to terminate the test at any time (even after the informed consent has been signed).
6. When the patient does not have the ability to understand the nature and consequences of the test and/or lacks the capacity to give informed consent, two physicians must independently document that testing appears to be vital to either the diagnosis or medical treatment of the patient.
7. An HIV test on a patient cannot be requested by a third party, including a health care worker.
8. After the results of the HIV test are received by the attending physician/NP, post-test counseling must occur if the patient tested positive.

Implemented: 11-91
Reviewed: 6-92
Reviewed: 5-95
Reviewed: 8-1999

Reviewed: 11/00
Reviewed: 01/02
Revised 08/03
Reviewed: 06/04

1. When an HIV test is ordered, the Unit Clerk contacts one of the approved HIV Counselors.
   - 1.1 The HIV counselor meets with the patient or guaridan for pre-test counseling which includes, but is not limited to: information on HIV transmission and prevention, the benefits of being tested, the psychological and emotional aspects of the test, the HIV antibody test and procedure, disclosure and discrimination.
   - 1.2 The patient or guardian must sign an informed consent form after the pre-test counseling before the HIV test can be conducted.
   - 1.3 The patient if an adult has the right to refuse testing or to terminate the test at any time (even after the informed consent has been signed).
   - 1.4 When the patient does not have the ability to understand the nature and consequences of the test and/or lacks the capacity to give informed consent, two physicians must independently document that testing appears to be vital to either the diagnosis or medical treatment of the patient.
2. An HIV test on a patient cannot be requested by a third party, including a health care worker;
   - 2.1 Those involved in a percutaneous blood exposure or high risk behaviors are requested to permit testing for HIV.
3. If the patient is a new admission or has had possible exposure to HIV through high risk behaviors a second HIV test is drawn three months after the initial HIV test.
   - 3.1 The patient or guardain must sign a second HIV informed consent form prior to the second blood draw for HIV testing.
   - 3.2 The Infection Control Nurse notifies the Medical Services provider for the specific patient that a second HIV test must be ordered.
4. After the patient or guardian has signed the informed consent form, it is returned to the Unit Clerk.
5. The Unit Clerk then orders the test and files the signed consent form in the patient's chart.
6. After the results of the HIV test are received by the attending physician/NP, post-test counseling must occur if the patient tested positive.

Revised: 5/98
Revised: 8/1999
Revised: 11/1999
Revised: 12/1999
Reviewed: 11/00
Reviewed: 01/02
Revised 08/03
Reviewed: 06/04

Policy

The Utah State Hospital handles all patient medical records in a confidential manner. The results of HIV tests are maintained as confidential with disclosure based only upon the need to know in order to provide quality patient care.

Procedure

1. HIV antibody test results are routed to the Infection Control Coordinator.
2. Positive HIV results are forwarded to the State Department of Health as mandated by law.
3. Disclosure of positive test results is limited to the patient's treatment team and unit staff. Lab results are posted in the patient record, which is a confidential document.
4. Hospital employees practice standard precautions and therefore a greater area of disclosure within the hospital is not necessary for quality patient care or protection of health care workers
5. Disclosure to outside providers is done only if the disclosure is necessary to provide appropriate follow-up care for the patient following discharge.

Implemented: 11-91
Reviewed: 6-92
Reviewed: 5-95
Revised: 6-98
Reviewed: 8-1999
Revised: 11/00
Reviewed: 01/02
Reviewed 08/03
Reviewed: 06/04

Policy

The Utah State Hospital promotes prevention of transmission of HIV.

Procedure

1. The Utah State Hospital employs Standard Precautions for all patients, which is that blood and body fluids of all patients are handled as if they contain bloodborne pathogens.

    1.1 The following barrier precautions are used on all patients based on anticipated contact with body fluids:

        1.1.1 Gloves are worn when handling any body substances such as blood, fees, urine, wound drainage, sputum, etc.;

1.1.2 Gowns are worn to prevent soilage of clothing;

1.1.3 Masks are worn to filter aerosol droplets to or from patients.

1.2 Hand washing is the single most important means of preventing the spread of infection and should occur between patient care assignments, i.e.., treating one patient, then treating another.

2. The hospital follows CDC recommendations for prevention of transmission of HIV to patients from health care workers (HCWs).

3. Patients who have aggressive sexual acting out behaviors or a history of sexually aggressive behavior are assessed for the need of a private bedroom to reduce the risk of transmission of sexually related diseases to other patients.

3.1 Sexual education is available for all patients, based upon the patient's level of understanding.

3.2 When deemed necessary, a patient may be assigned a one-to-one to decrease possible harm to other patients.

Revised: 4-95
Reviewed: 8-1999
Reviewed: 11/00
Reviewed: 01/02
Revised 08/03
Reviewed: 06/04

Policy

All Utah State Hospital employees are trained in correct hand washing techniques to prevent transmission of infectious diseases.

Procedure

1. Employees wash their hands in the following situations:

1.1 before handling clean patient-care equipment and supplies;

1.2 before serving food;

1.3 between contacts with patients;

1.4 after going to the restroom;

1.5 after handling soiled linens; and,

1.6 after removal of gloves.

2. When hand washing is not immediately feasible,an alcohol based hand cleaner or antiseptic towelettes are provided. When alcohol based hand cleansers or towelettes are used, hands are washed with soap and running

water as soon as possible.

Implemented: 6-92
Reviewed: 5-95
Revised: 6-98
Revised: 9-1999
Reviewed: 11/00
Reviewed: 01/02
Revised 08/03
Revised: 06/04

Policy

Infectious waste disposal is the responsibility of the Environmental Services Department. Infectious waste material will be designated as such by nursing personnel by placing in color-coded liners of low-density polyethylene at least three millimeters thick.

Procedure

1. Infectious waste is properly bagged in **RED** liners and tied.
   - 1.1 Bagged infectious waste is deposited in "Infectious Waste Containers" by nursing personnel
   - 1.2 Infectious waste container buildings are located outside the Medical Services, Rampton ll , Girl's youth, and Forensic buildings. The Rampton l building has a **RED** Infectious Waste Container in the soiled utility rooms located on the north and south side of the building.
   - 1.3 Each container holds two impervious receptacles which are lined with infectious waste liners draped over all the edges.
2. Infectious waste containers are inspected two times weekly.
   - 2.1 The waste is transported to the designated holding room of the Medical Services Building via housekeeping van.
   - 2.2 Prior to removal, the red liners are tied at the top.
   - 2.3 Infectious waste containers are picked up by a contracted waste management company every thirty days
3. The housekeeping van used for transporting infectious waste is cleaned and disinfected after each use.
4. All infectious waste containers and the holding room of the Medical Services Building are cleaned and disinfected every thirty days.
5. During all handling, cleaning, and decontaminating procedures, all personnel practice universal precautions, including, but not limited to, the following safety wear: rubber gloves and smocks that protect clothing.

5.1 After the completion of handling infectious waste, all employees are to immediately remove their gloves and wash their hands with antibacterial soap.

5.2 Eating, drinking, smoking, handling cosmetics, and handling contact lenses are prohibited during handling and storage of infectious waste and the cleaning of containers, the holding room, or the van.

Implemented: 6-92
Reviewed: 5-95
Revised: 6-98
Revised: 8-1999
Revised: 11/00
Reviewed: 01/02
Reviewed:08/03
Revised: 06/04

Policy:

Contaminated waste disposal is the responsibility of the Environmental Service's Department. Contaminated waste material is designated as such by nursing and laboratory personnel by placing in color-coded liners of low-density polyethylene at three millimeters thick.

Definition:

Contaminated waste: a broad term to describe any waste which could potentially spread an infection or harm someone handling the waste. Including: sharps (i.e. needles, scalpels, broken glass, razors); single patient use items visibly contaminated with blood (i.e. dressings, gloves, feminine hygiene products); discarded pathologic waste (i.e. unused blood, extracted teeth or tissue samples): and, other soiled items determined by the RN on duty to be contaminated or potentially infectious (i.e. an item used by the patient in an attempt to harm him/herself, single patient use items soiled with feces from a patient with infectious diarrhea or infectious sputum [TB]).
Examples of single patient use items: dressings, chux, nasogastric tubes, IV catheter, urinary drainage systems, oxygen tubing, suction equipment.

Procedure:

1. During all handling, cleaning and decontaminating procedures, personnel practice standard precautions.
   - 1.1 Wear rubber gloves and smocks to protect clothing.
   - 1.2 As soon as feasible after removal and disposal of their gloves, employees wash their hands with antibacterial hand cleanser or soap and water.
   - 1.3 Eating, drinking, smoking, applying cosmetics and handling contact lenses are prohibited during handling and storage of infectious

waste and the cleaning of container, the holding room and the van.

2. Contaminated waste is properly bagged in **RED** liners and tied.
   - 2.1 Bagged contaminated waste is deposited in the “Contaminated Waste Containers” by nursing.
   - 2.2 Contaminated waste containers are located outside the Rampton ll, Medical Services , Forensic and Girl"s youth buildings.
   - 2.3 **RED** Contaminated Waster Containers are located in the soiled Utility rooms on the north and south sides of the Rampton l building.
   - 2.4 Each container holds two impervious receptacles which are lined with contaminated waste liners draped over all the edges.
3. Contaminated waste containers are picked up two times weekly.
   - 3.1 The receptacles are transported to the designated holding room of the Medical Services Building via the housekeeping van.
   - 3.2 Prior to removal, the red liners are tied at the top.
   - 3.3 Contaminated waste containers are picked up by the waste management company every thirty days.
4. The housekeeping van used for transporting contaminated waste is cleaned and disinfected after each use.
5. All contaminated waste containers and the holding room of the Medical Services Building are cleaned and disinfected every thirty days or at any time when there is visible contamination.

Implemented:12/15/97
Revised: 1/98
Revised: 4/98
Revised: 8/1999
Revised: 11/00
Reviewed: 01/02
Reviewed: 08/03
Revised: 06/04

Policy

All soiled linen is treated as contaminated.

Procedure

1. Unit personnel place soiled linens in water-proof bags in the patient's room or area of contamination.

    1.1 If linen is saturated in blood it may be placed into a regular plastic bag or a plastic yellow bag if available. This is for the *sole* purpose that the blood does not ruin other linen. It does not change the decontamination process of soiled laundry.

2. Linens are handled as little as possible to prevent release of organisms into the air.

3. All laundry bags are tied or closed completely when full.

4. All soiled linens in bags are delivered from the unit to the soiled-linen receiving area.

5. Workers in the soiled-linen receiving area are required to wear an apron and gloves when in contact with used laundry bags.

6. Germicidal hand cleaners are provided for washing hands immediately after contact.

7. A germicidal cleaner and a spray tank is used to sanitize the laundry baskets, carts, and delivery van.

Implemented: 6-92
Revised: 5-98
Revised: 9-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed: 08/03
Reviewed: 06/04

Policy

Biohazard labels are affixed to all containers of potentially infectious materials.

Procedure

1. Biohazard warning labels are affixed to the following:

    1.1 containers of regulated waste;

1.2 refrigerators and freezers containing blood or potentially infectious material;

1.3 containers used to store, transport, or ship blood or other potentially infectious materials except:

1.3.1 when substituted with red bags or red containers, *i.e.*., sharps containers, garbage;

2. Individual containers of blood or other potentially infectious materials that are placed in a labeled container do not require individual labels.

3. Contaminated equipment must be labeled if not in a container which is labeled.

Implemented: 6-92
Reviewed: 5-95
Reviewed: 5-98
Revised: 8-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed : 08/03
Reviewed: 06/04

Policy

All equipment and environmental and working surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials.

Procedure

1. Contaminated work surfaces are decontaminated with an appropriate disinfectant after completion of procedure.
2. When a work surface is overtly contaminated with any spill of blood or other potentially infectious materials:
   - 2.1 the employee must wear gloves;
   - 2.2 the spill is absorbed with dry paper towels which are disposed of in a contaminated-waste container;
   - 2.3 the contaminated area is sprayed with an appropriate disinfectant until it is visibly wet;
   - 2.4 the disinfectant must remain on surface for the appropriate time-frame; and,
   - 2.5 the area is wiped with dry paper towels and rinsed with clean water.
3. When protective coverings, *i.e..*, plastic wrap, aluminum foil, imperviously backed absorbent paper, used to cover equipment become overtly contaminated, they are removed and replaced as soon as possible.
4. All waste receptacles are decontaminated as indicated in Housekeeping policies and procedures.
5. Broken glassware which may be contaminated is cleaned up by using mechanical means, *i.e..*, a brush and dust pan, forceps.
6. Reusable instruments, *i.e..*, forceps, scissors, needle drivers, that are contaminated with blood or other potentially infectious materials are placed in a drain tray found in white transport containers, rinsed, drained, and then placed in a transport container with a lid for transport to Central Supply.
   - 6.1 Transport containers are available through Central Supply.

Implemented: 6-92
Revised: 5-95
Revised: 5-98
Revised: 8-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed : 08/03

Policy

The Central Supply department has adequate direction, staffing, and facilities to perform all necessary functions.

Procedure

1. The Director of Central Supply is a member of Nursing Administration.
2. The number of support personnel is related to the scope of service provided.
3. The Central Supply employees participate in a program of continuing education.
    - 3.1 New employees receive orientation and on-the-job training.
    - 3.2 Orientation and continuing education are documented.
4. There are written policies and procedures for decontamination performed in Central Supply and elsewhere in the hospital which include at least the following:
    - 4.1 Receiving, decontaminating, cleaning, preparing, disinfecting, of reusable items.
    - 4.2 Assembling, wrapping, storing, distributing, and quality control of sterile equipment and supplies.
    - 4.3 The frequency and use of sterilization monitors in the Dental clinic.
    - 4.4 Designation of shelf life dates for all commercially-prepared sterile items to assure a limit on the length an item is to be considered safe to use. When an expiration date is not specified on in-house-sterilized or commercially-prepared sterile items, a conspicuous statement on the package, indicating sterility is guaranteed if package integrity is not compromised, represents an acceptable day-to-day expiration date.
    - 4.5 Supplies may be acquired by the hospital security officer or SSRN after hours or when Central Supply is closed.
    - 4.6 Records are kept of all sterile supplies maintenance and performance verification.
    - 4.7 There are policies and procedures concerning the recall, disposal, and/or reprocessing of outdated materials.
    - 4.8 Provisions have been made for emergency recall when special warnings are issued by the manufacturer. Physicians are notified if

patient exposure is known.

4.9 There are specific policies and procedures concerning, floors, utensils, and equipment used in Central Supply.

5. The design of the Central Supply area provides for separation of soiled and/or contaminated supplies from clean and/or sterile supplies. The area has a functional work-flow pattern.

6. Equipment is of adequate design, size, and type to provide effective decontamination, disinfection, cleaning, packaging, storing, and distributing of medical instruments and supplies to provide a good quality of care for patients.

7. The Steris autoclave is tested with a biological indicator at least weekly.

Implemented: 5-22-89
Reviewed: 1-91
Revised: 6-92
Revised: 1-95
Revised: 6-98
Revised: 8-1999
Reviewed: 11/00
Reviewed: 01/02
Revised : 08/03

Policy:

Grooming and make-up techniques occur in a safe environment without cross contamination.

Procedure:

1. Every patient has their own grooming supplies and cosmetics (where applicable).
   1.1 Every patient has their own fingernail clippers and does not share it with other patients.
2. Grooming products are not shared, but used for a single patient, and when the patient is discharged, the remainder of the products are sent with the patient or discarded.
3. Immediate treatment of any wound obtained during grooming includes washing with warm soap and water followed by an application of Betadine and a bandaid if necessary.
   3.1 In all cases of puncture wounds, the need for Tetanus and Diphtheria booster is evaluated by the Medical Doctor.

Implemented: 3/2/95
Revised: 9-95
Revised: 4/98
Reviewed: 8/1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed: 08/03

Policy:

USH employs the guidelines for isolation that have been recommended by the Center for Disease Control (CDC).

Procedure:

1. Guidelines for isolation as recommended by the CDC's Hospital Infection Control Advisory Committee (HICPAC) emphasize patient to patient transmission of disease, while retaining some Employee Health components.
2. HICPAC Isolation Precautions, consist of two tiers.
   2.1 Standard Precautions are designed for the care of all patients regardless of their diagnosis or presumed infection status and is the primary infection control strategy.
      2.1.1 Standard Precautions combine the major features of Universal Precautions designed to reduce the risk of transmission of blood borne disease, and Body Substance

Precautions that are aimed at reducing the risk of transmission of disease from other moist body substances.

2.1.2 Standard Precautions apply to blood; all body fluids, secretions, and excretions, whether or not they contain visible blood; non-intact skin; mucous membranes.

2.2 Transmission-based precautions, the second tier of precautions, are specifically for patients with known or suspected epidemiologically important disease spread by airborne transmission, droplet transmission, or by contact with dry skin or contaminated surface.

2.2.1 These "empiric precautions" are designed to prompt implementation of transmission based precautions that are based on clinical symptoms and conditions while a more exact diagnosis is being sought.

3. Nursing may implement isolation precautions when a specific disorder is diagnosed or suspected. Orders for specific isolation must be obtained from Medical Services within 12 hours of initiation. Once ordered, isolation precautions are not discontinued or changed except as ordered by medical services.

4. Standard Precautions, typically, is sufficient for most patient care activities. However, isolation precautions may be indicated for specific disorders. The following is a description of airborne, contact and droplet isolation precautions and examples of when they are applicable:

4.1 **Airborne Precautions:** designed to reduce the risk of airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei of evaporated droplets that may remain suspended in the air for long periods of time, or dust particles containing the infectious agent. Special air handling and ventilation are required to prevent airborne transmission. These air handling/ventilation systems are currently NOT available at the Utah State Hospital. If airborne precautions are necessary, arrangements are made to have the patient transferred to another facility. Until transfer, in addition to Standard Precautions, patients are placed in a private room. Staff limit exposure to the patient, wear a mask and remain 3 feet from the patient, if possible. Patients wear a mask while being transported. Employees who are not immune to the specific disorder (i.e.-measles or varicella), must avoid contact with the patient. Examples of disorders needing airborne precautions include:

4.1.1 Herpes Zoster (in an immune compromised patient or with disseminated disease);

4.1.2 Measles (rubeola);

4.1.3 Tuberculosis (pulmonary-active or suspected); and,

4.1.4 Varicella (chickenpox).

4.2 **Contact Precautions:** designed to reduce the risk of transmission of epidemiologically important microorganisms by direct (person to person) or indirect (person to object to person) contact. In addition to Standard Precautions, placement of the patient in a private room is advisable. If a private room is not available nursing consults with Medical Services or Infection Control to evaluate options. Employees wear gloves during the course of providing care. Gloves are changed after contact with highly infective material and are removed before leaving the room. Hands are washed immediately after leaving the patient room with an antimicrobial agent or waterless antiseptic agent. Care is taken to avoid touching potentially contaminated environmental surfaces once gloves are removed. Gowns are worn if it is suspected that clothing will have substantial contact with the patient or environmental surfaces. The gown is to be removed before leaving the patient room. The patient is transported as little as possible, with care taken to protect against additional environmental contamination. Multiple patient use items (i.e.-blood pressure monitoring equipment) are cleaned and disinfected before being used on another patient. Examples of disorders needing contact precautions include:

4.2.1 Abscess (major, draining);

4.2.2 Cellulitis (uncontrolled drainage);

4.2.3 Clostridium difficile infections (enterocolitis/gastroenteritis);

4.2.4 Conjunctivitis (acute viral);

4.2.5 Decubitus ulcer (major, infected);

4.2.6 E. coli infections (incontinent patients);

4.2.7 Hepatitis A (incontinent patients);

4.2.8 Hepatitis B and/or C (blood exposure)

4.2.9 Herpes simplex (mucocutaneous disseminated or severe);

4.2.10 Herpes zoster (immune compromised patient or disseminated);

4.2.11 Impetigo;

4.2.12 Multidrug-resistant organisms (infection or colonization);

4.2.13 Respiratory syncytial virus (immune compromised patient);

4.2.14 Scabies;

4.2.15 Varicella (chicken pox); and,

4.2.16 Wound infections (major).

4.3 **Droplet Precautions:** designed to reduce the risk of droplet transmission of infectious agents. Involves contact of the conjunctivae or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets. Droplets do not remain suspended in the air, therefore special air handling and ventilation are not required. In addition to Standard Precautions, it is recommended that the patient be placed in a private room. When this is not possible, nursing consults with Medical Services or Infection Control to evaluate placement options. A minimum of three (3) feet, whenever possible, is maintained between the infected patient and other patients or visitors. A mask is used when working less than three feet from the patient. When transporting the patient, he/she wears a mask. Examples of disorders needing droplet precautions include:

4.3.1 Diphtheria (pharyngeal);

4.3.2 German measles (rubella);

4.3.3 Haemophilus influenzae (known or suspected);

4.3.4 Influenza;

4.3.5 Meningococcal pneumonia;

4.3.6 Mumps;

4.3.7 Mycoplasma pneumonia;

4.3.8 Parvovirus B19 (Fifth Disease);

4.3.9 Pertussis; and,

4.3.10 Pneumonia (adenovirus).

4.4 Nursing staff with any concerns or questions about the need for isolation precautions should contact Infection Control as soon as possible.

Implemented: 9/95
Revised: 4/98
Revised: 12/98
Revised: 8/1999
Revised: 11/00
Reviewed: 01/02
Reviewed : 08/03

Protocol:

Patients infested with pediculosis are treated according to the following protocol.

Definition:

Infestation of the human body by a visible, wingless parasite with three pair of legs ending in claws (2-3mm long). There are three types of lice (see below). Humans are the only natural reservoir. Outbreaks are correlated with over-crowding, and inadequate facilities for keeping people and clothing clean.

CHARACTERISTIC	***BODY & HEAD LICE***	***PUBIC LICE***
Time for incubation of ova	8 - 9 days	8-9 days
Time from egg to adult	10 days	15 days
Life span of female	30-35 days	35 days

Common site of Infection

Head: especially the back of head, neck and ears, rarely eyelashes, Genital region, axillae

Body: Shoulders, waist and areas of clothing contact

Time of survival off host Head: 2 days Body: 4-7 days

TRANSMISSION:

A. Head lice are transmitted by direct contact with personal items such as brushes, combs and bedding.

B. Body lice are transmitted by direct contact or contact with clothing or bedding (Body lice cling to clothing or bedding--especially seams.) Body lice are seldom found on the body of an infected person.

C. Pubic lice are transmitted by close physical contact--especially sexual. (Transmission via clothing or bedding is rare because of rapid death of lice off the human host).

TREATMENT:

A. Treatment of choice for head or pubic lice is Pyrethrins (RID, A-200 pyrinate) or Permethrin 1% (NIX).
   1. Shampoo - rub affected areas vigorously for four minutes.
   2. Repeat treatment in seven days, as it is not considered ovicidal.

B. Eyelid involvement can be treated with a petrolatum ophthalmic ointment or 1% yellow oxide of mercury ophthalmic ointment when

ordered by the NP/MD.

C. Patients with body lice are not usually treated unless the infestation is of epidemic proportions.

D. Treat only if high risk for lice or if infected. The exception is to treat the sexual contacts of the infected patients.

DISINFECTION OF FOMITES:

1. Inanimate objects such as brushes, combs, caps, scarves, coats, etc:
   A. The eggs of body lice have more potential for spreading by fomites than any other type of lice, because eggs can survive up to thirty days off a host. Eggs do not hatch in an inanimate environment at room temperature and can be destroyed through a disinfection process.
   B. Methods of disinfection (with known infestation):
      1. Machine washing, drying, dry cleaning, or ironing (temperature of more than 60 C or 140 F for 5-10 minutes).
      2. Storage of non-washables in sealed plastic bags for specific time periods.
         2.1 Ten to fifteen days for head lice.
         2.2 Seven days for pubic lice.
         2.3 Storage is not usually recommended for body lice as more than 30 days are required for eggs of this type to hatch.

HOSPITAL MANAGEMENT:

A. Only high-risk (for pediculosis) new admissions receive a shampoo with a recommended agent (i.e. Triple X or Rid) per physician/practitioner order.

B. Isolation is not required as long as clothing and bedding have been properly disinfected and patients do not share items.

C. Hospital employees who have contact with patients need not be treated unless they show evidence of infestation.

D. Other than vacuuming, special cleaning of rooms is not recommended.

E. Mattresses and upholstered furniture can be disinfected with R & C spray in two applications seven days apart.

LAUNDRY:

A. Linen should be handled per hospital protocol.

B. Linen should be held away from the body.

Implemented:1-91
Revised: 4/98
Revised: 8/1999
Revised: 11/00
Reviewed: 01/02
Reviewed : 08/03
Reviewed: 06/04

Protocol:

Patients infested with pediculosis-scabies are treated according to the following protocol.

DEFINITION:

Infestation of the human body by a minute, wingless parasite with four pair of legs and measuring less than 0.5 mm long. It is sometimes known as the common itch mite. Humans are the natural reservoir. Eggs are laid in the upper layer of the epidermis. Outbreaks can be correlated with delayed diagnosis and lack of patient isolation of persons who are in close contact with large groups of individuals.

CHARACTERISTICS

Time for incubation:

Primary infestation 3-6 weeks

Re-infection Immediately (due to sensitization)

Time from egg to adult: 10 days

Life span of Adult female : 30 days

Common site of infection:

Primary involvement : Hands, webs of fingers, wrists, extensor surface of knees and elbows, surface of feet.

Secondary involvement: Armpits, buttocks, waist, arms, nipples, trunk, legs, penis, scrotum.

Time of survival **off** host: 2-10 days on fomites

TRANSMISSION:

A. Most frequently, direct contact with infected persons.

B. Less frequently, contact with clothing or bedding (fomites).

C. Spread on the body by manual transfer (scratching).

PRESENTATION:

A. Intense itching, increased at night.

B. Scratching produces bleeding, scab formation and possibly a secondary infection.

C. Two-thirds of cases have "burrow-like" pruritic lesions.

D. Burrow-like lesions are less frequent in infants and children. Instead, scabies presents as eczematous involvement of head, neck, palms,

and soles.

DIAGNOSTIC TESTS:

A. Extraction with needle or blade.

B. Skin scraping with microscopic exam for identification of mites or fecal pellets.

C. Skin biopsy.

PROCEDURE (TREATMENT):

A. Topical application of scabicide to neck, trunk, and all extremities with Permethrin 5% (Elimite cream). A single application is applied over the entire body and is left on for 8-14 hours. It is then thoroughly washed off (soap may be used).

HOSPITAL MANAGEMENT:

A. Diagnosis of scabies is considered with any pruritic rash involving the hands, wrists and elbows.

B. Intimate clothing as well as bedding is washed by machine in 41 C (106) water or bagged for 10 days.

C. It is not usually necessary to clean outer wear or furniture, rugs, etc.

D. Roommates and sexual contacts are treated prophylactically.

E. Direct care providers wear gloves until after completion of medication routine.

F. Asymptomatic direct care providers who have had skin-to-skin contact with infested patients may be treated.

G. Patients with scabies are isolated from other patients for 24 hours after treatment.

Implemented:1-91
Revised: 4/98
Reviewed: 8/1999
Revised: 11/00
Reviewed: 01/02
Reviewed : 08/03
Reviewed: 06/04

Policy

Each patient who uses a safety razor, has his/her own razor.

Procedure

1. The person assigned to order supplies orders enough so that each patient can have his/her own razor.
2. Razors are distributed (as per procedure of each unit) by a designated employee.
   - 2.1 Razors are stored individually with each patient's name visible.
   - 2.2 Razors are replaced as needed.
4. Electric razors that are shared, are cleaned with isopropyl alcohol between patients.
   - 4.1 The blades must be soaked in isopropyl alcohol for one to two minutes and then allowed to air dry.

Implemented: 11/30/87
Revised: 4/98
Revised: 8/1999
Reviewed; 11/00
Reviewed: 01/02
Reviewed : 08/03
Reviewed: 06/04

Policy:

Sewing needles are handled as any other sharp object suspect of blood transfer and are used **ONE TIME ONLY AND DISPOSED.**

Procedure:

1. Needles used for hand sewing are readily available from the warehouse.
2. Sewing needles are disposable and are given out by nursing staff for **one time use only.**
3. Sewing needles are disposed of in puncture proof sharps containers, and disposed of with contaminated waste.
4. Immediate treatment of any wound includes washing with warm soap and water.
5. The need for Tetanus and Diphtheria booster is evaluated in all cases of puncture wound.

Implemented: 3/2/95
Revised: 4/98
Reviewed: 8/1999
Reviewed: 11/00

Policy

Patients who spit at other patients, hospital staff, visitors, and/or hospital furnishings wear masks as necessary. Masks are used to provide a sanitary environment in maintaining the Hospital infection control program.

Procedure

1. Masks are obtained from Central Supply and are kept in the unit OSHA cabinet..
2. The unit RN on shift determines if it is necessary for a patient to wear a mask.
   - 2.1 The unit RN documents in the progress notes every shift or every incident when the mask is required.
   - 2.2 Patients who refuse to stop spitting may be required to wear a mask.
   - 2.3 The unit RN is responsible to assure that there are no harmful side effects associated with the patient's wearing a mask (i.e. compromised breathing, tightness of ties/elastic), and charts the same in the progress notes once a shift.
   - 2.4 The mask is removed when the patient demonstrates by his/her behavior that he/she will not spit.
   - 2.5 A doctor's order may be obtained for restraints if the patient refuses to wear the mask and continues to spit.

Implemented: 01/25/88
Revised: 4/98
Revised: 9/1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed : 08/03
Reviewed: 06/04

Reporting to Infection Control:

Nursing staff, physicians, nurse practitioners and all staff are responsible for reporting known or suspected infections to the Infection Control Coordinator. Prompt reporting of infections improves patient care and allows infection control coordinator an opportunity to accurately track infections and respond to patient/staff needs. Specific conditions which should be reported to infection control as soon as possible are noted below. Staff should report any additional symptoms, disorders or concerns whenever they are noted.

1. Reporting may be completed by any employee of the hospital.

2. Reporting may be completed in person, in writing, via E-mail (Infection Control Ic) or via phone (messaging service available).

3. Requests for information, education or assistance may be made at the time of the report, or at any time staff determine a need.

4. Reports should be made, at a minimum, when the following conditions occur:

   4.1 An anti-infective is ordered (the order should include the actual or suspected diagnosis);

   4. 2 A culture is obtained for a suspected infection;

   4.3 A patient has an open, draining wound;

   4.4 Temperature over 100 degrees (F); and when,

   4.5 Two or more patients on a unit have similar symptoms (i.e.-nausea, vomiting, diarrhea).

Reporting to outside agencies:

Medical providers and Infection Control are responsible for reporting certain communicable diseases to outside agencies. Each confirmed or suspected case of the following diseases is required by law (Communicable Disease Rule R386-702) to be reported to the Utah Department of Health or the local health department. Diseases in **bold** print must be reported immediately, by telephone. All others may be reported using a confidential morbidity report card. Report cards are available in the Infection Control Office. Patients at the Utah State Hospital may be diagnosed with any of the following disorders. Patients may be at higher risk for the underlined items.

1. The following conditions must be reported, if they are <u>diagnosed</u> or suspected while the patient is at the Utah State Hospital:

Acquired Immunodeficiency Syndrome
Amebiasis
Anthrax
Botulism
Brucellosis
Campylobacteriosis
Cancer**
<u>Chancroid</u>
<u>Chickenpox*</u>
<u>Chlamydial infections</u>
Cholera
Coccidioidomycosis
Colorado tick fever
Diphtheria
Echinococcosis
Encephalitis
<u>Foodborne illness</u>
<u>Giardiasis</u>
<u>Gonorrhea</u>
Gonococcal ophthalmia
Granuloma inguinale

Haemophilus influenzae	Hepatitis A (active)
Hepatitis B (active/carrier)	
Hepatitis (other viral: C, Delta, etc.)	HIV infection
Influenza*	
Legionellosis	Leprosy
Leptospirosis	
Lymphogranuloma venereum	Malaria
Meningitis (aseptic/bacterial)	
Meningococcemia	Mumps*
Pelvic inflammatory disease	
Pertussis	**Plague**
Poliomyelitis	
Q fever	**Rabies** (animal/human)
Relapsing fever (tick/louse)	
Rheumatic fever	Rocky Mountain Spotted
Rubella	
Rubeola	Salmonellosis
Shigellosis	
Staphylococcal disease*	Syphilis
Tetanus	
Toxic shock syndrome	Trichinosis
Tuberculosis (active)	
Tularemia	**Typhoid** (case/carrier)
Typhus	
Yellow Fever	*Unusual diseases or outbreaks of any kind*

*Report only number of cases
**Cancer should be reported to the Utah Cancer Registry

2. Medical providers may choose to notify the outside agencies personally, or may request that Infection Control report. Infection Control may identify concerns based on laboratory data and follow-up with the medical provider prior to reporting.

Proposed: 12-1998
Reviewed: 9-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed : 08/03
Revised: 06/04

Policy:

Sharp items used for nursing procedures; including needles, lancets, scalpels and similar items, are handled with extreme caution. These items may provide a route of transmission for bloodborne pathogens or may be used by a patient to harm him/herself or others. Nursing and Medical Services are responsible for the safe use and disposal of these items.

1. Whenever a sharp item or instrument is used during a nursing procedure, nursing is responsible for monitoring its appropriate use and disposal. When sharps are used in a procedure, nursing and medical services are responsible for appropriate use and disposal.

2. Nursing monitors the number of sharps used in a procedure and assures that **ALL** are safely removed and returned to the appropriate area, or are disposed of properly.

3. After use, **NO sharp is re-capped or re-covered**. All sharps used in patient procedures at the hospital are ***single use*** items.

4. Sharps are disposed of in appropriately identified, impervious sharps containers.

5. Sharps containers are replaced, sealed and disposed of according to infectious waste management guidelines when they are 3/4 full.

6. Assistance is appropriate when completing procedures with a sharp item or instrument, for protection of both patient and staff.

7. Any exposure to a used or contaminated sharp is reported. The employee follows the guidelines in the policy: Occupational Exposure to Blood or Blood Products.

1. Once needles have been used in a patient procedure (i.e.-injection, IV start) they are **NEVER re-capped or re-used.** *Needles are not handed from one person to another for disposal.*

2. Nursing must always use a needle protection device or syringes with built in safety devices.

    2.1 Available from Central Supply;

    2.2 Used in the following manner:

        2.2.1 Needle protection devices cannot be used on pre-filled syringes with a permanetly attached needle.

    2.3 When using Safety-Lok syringes, use in the following manner:

        2.3.1 Grasp sleeve firmly by green band and twist flanges to loosen sleeve.

        2.3.2 After injection fully retract needle into safety sleeve until it locks and a click is heard and the green band fully covers the red band.

        2.3.3 Pull back on the flanges do not pull forward on safety sleeve.

3. Nursing may take a small sharps container with them to the area where the procedure will be completed (nursing is responsible for the safe return of the container to a secure location); or,

4. Nursing may perform the procedure in an area with easy access to an

appropriate sharps container (i.e.-treatment room, medication room).

1. Once lancets have been used in a patient procedure (i.e.-blood glucose monitoring) they are **NEVER re-used.**
2. Lancets used at the Utah State Hospital are self-contained, self-retracting units.
   - 2.1 Lancet needles are only exposed when the device is activated by pressing on the cap.
   - 2.2 Nursing staff, or patients who have been approved to use the equipment independently, activate the lancet by pressing on the cap to complete the procedure.
   - 2.3 Once the cap is released the lancet needle automatically retracts into the device.
3. Used lancets are disposed of immediately after use in an appropriate sharps container.
   - 3.1 *Lancets are not handed from one person to another for disposal.*

1. Once scalpels have been used in a patient procedure (i.e.-incision and drainage), they are **NEVER re-capped or re-used.**
2. Procedures requiring the use of a scalpel are completed where there is easy access to an appropriate sharps container.
3. The person completing the procedure is responsible for placing the used scalpel in an appropriate sharps container.
4. If using a non-disposable handle with the scalpel blade the person disposing of the scalpel blade
   - 4.1 Retrieves a pair of hemostats;
   - 4.2 Using the hemostats, carefully grasps the scalpel blade;
   - 4.3 Pulls the scalpel blade straight from the device; and,
   - 4.4 Places the scalpel blade in an appropriate sharps container.

Proposed: 12/1998
Approved: 1/1999
Revised: 6/1999
Revised: 7/1999
Revised: 9/1999
Revised: 11/00
Revised: 04/01
Reviewed: 01/02
Reviewed: 08/03
Revised: 06/04

Hepatitis Panel

Adult patients are screened on admission for hepatitis A, B and C. Patients under the age of 18 are screened only when deemed necessary by the admitting physician/practitioner.

1. Orders for hepatitis panels are written by the admitting physician/practitioner.
    1.1. The hepatitis panel includes screening for hepatitis A IgM antibodies;
    1.2 It includes screening for hepatitis B antibodies and surface antigen; and,
    1.3 It includes screening for hepatitis C antibodies.
        1.3.1 If the patient is positive for hepatitis C antibodies a hepatitis C-RIBA is completed, upon order of the medical provider.
2. Orders are transcribed according to existing USH policies and procedures.
3. Results are forwarded to Infection Control from the contract laboratory and to the patient record and physician/practitioner according to existing USH policies and procedures.
4. Infection Control reports the following positive results to the Utah County Health Department;
    4.1 Positive hepatitis A antibodies **with** a positive IgM;
    4.2 Positive hepatitis B surface antigen; and,
    4.3 Positive hepatitis C antibodies.
5. Patients with a positive hepatitis A **IgM** are excluded from the following activities, until released by the unit physician/practitioner:
    5.1 Preparing food;
    5.2 Serving food;
    5.3 Cleaning in food-service areas; and,
    5.4 Sharing food with other patients or staff.
6. It is recommended that patients with reactive Hepatitis C antibodies receive vaccines for Hepatitis A and B.

Tuberculosis Screening

1. All patients at the Utah State Hospital are screened for tuberculosis through a tuberculosis skin test (PPD). Screening is completed upon admission if present admission is at least one year from the previous admission and throughout hospitalization, on an annual basis.
    1.1 Tuberculosis is an airborne infection and is highly communicable.
    1.2 Active tuberculosis can cause significant respiratory and systemic illness, which may result in:

1.2.1 Chronic lung problems;

1.2.2 Respiratory distress; and/or,

1.2.3 Death.

1.3 Tuberculosis is most frequently spread through exposure in institutional settings and/or settings where there is close contact with others.

1.4 Persons with compromised immune systems are at increased risk, including:

1.4.1 those with diabetes;

1.4.2 those with cardiovascular disease;

1.4.3 those with a compromised respiratory system (including smoking);

1.4.4 those with acquired immune deficiency syndrome (AIDS);

1.4.5 those taking immunosuppressive drugs (including psychotropic medications); and,

1.4.6 those with nutritional deficiencies.

1.5 Tuberculosis is a primary health concern of local and national health departments, as the incidence has dramatically increased.

1.6 Screening all patients protects other patients, staff and visitors from unnecessary exposure to Tuberculosis.

1.6.1 All hospital employees are mandated to complete annual Tuberculosis screening.

1.7 Early recognition of exposure significantly decreases the likelihood of long-term problems associated with Tuberculosis.

2. PPD testing is completed by the Infection Control Coordinator, or designee.

2.1 The two step testing method for tuberculosis is not indicated at USH (because USH is a "very low risk" facility) and is therefore not implemented.(See IC Committee mtg. minutes April 2000 for rationale)

2.2 New admission and annual PPD's are ordered by medical services;

2.3 Patient care units notify the Infection Control Coordinator of all admissions for initial evaluation;

2.3.1 The Infection Control Coordinator monitors all patients for annual evaluation.

2.4 PPD's are read within 48 to 72 hours of placement.

2.5 Results are recorded in the patient's Electronic chart in the lab/x-ray section.

2.6 Patient charts are flagged with a **+PPD** sticker, if reactive.

3. Patients with a known history of reactive PPD are evaluated on admission and a chest x-ray is ordered.

3.1 If a patient has received treatment for tuberculosis infection or disease, no follow up is needed if the patient remains asymptomatic.

3.2 When a patient has a positive PPD skin test and has documentation of three consecutive negative Chest X-rays in the patient record, no further TB testing is required if the patient remains asymptomatic.

4. Employee PPD testing procedure is outlined in Chapter 4: Section 8 Employee Health Requirements and Records.

Proposed: February 1999
Approved: March 1999
Revised: June 1999
Reviewed: September 1999
Revised: December 1999
Revised: May 2000
Revised: 11/00
Revised: 02/01
Revised: 04/01
Reviewed: 01/02
Reviewed: 08/03
Revised: 06/04

Policy

Patients are tested on admission for Hepatitis A, B and C. Patients with positive Hepatitis A (IgM reactive), Hepatitis B surface antigen reactive and Hepatitis C antibody reactive are provided counseling on transmission, symptoms and prevention of the specific disease.

Procedure

1. The results of all Hepatitis panels are forwarded to the Infection Control Nurse.

2. The Infection Control Nurse identifies patients with reactive results and through entering the the patient's lab results in e-chart the UND and unit RN are notified of the patients who need counseling.

3. The UND and/or unit RN completes the counseling for each patient and charts (via e-chart) that the hepatitis counseling has been completed. E-chart automatically forwards an e-mail to the Infection Control Nurse stating that the counseling has been completed.

3.1 If the counseling is not completed within one week of the initial notification another e-mail is sent to the unit RN and UND reminding

them to complete the hepatitis counseling.

4. Hepatitis counseling is provided by the Infection Control Nurse, or designee, and includes:

   4.1 Modes of transmission and prevention of further transmission, specific to the disease;

   4.2 Major symptoms of the disease; and,

   4.3 Lifestyle considerations.

5. Family members and/or significant others are included in counseling if the patient approves.

Proposed: March 1999
Approved: March 1999
Revised: September 1999
Reviewed: 11/00
Revised: 01/02
Reviewed: 08/03
Reviewed: 06/04

Policy

All patients infected or colonized with MRSA are treated according to the following protocol.

Protocol

1. MRSA infected or colonized patients must be placed in a "modified" contact isolation which consists of:

   1.1 The ideal room placement is a private room or a room with another MRSA colonized patients. However, the MRSA colonized patient could share a room with a non-MRSA colonized patient who has no invasive sites (i.e. Foley, gastrostomy feeding tube, IV) or open wounds.

   1.2 The patient may leave the room and go to activities as long as good hygiene is observed.

   1.3 Handwashing must be rigorously practiced by patients and staff.

   1.4 Gloves are indicated, when there is a possibility of direct contact with patient secretions and/or body fluids.

   1.5 Masks are worn when staff is caring for a patient who has a tracheostomy or cough and has MRSA colonization in the sputum.

2. "Modified" isolation is discontinued when three (3) consecutive negative cultures, taken 48 hours after therapy for MRSA has ended and at least 24 hours apart, have been obtained from the original site of infection or colonization, other wounds and nares.

3. Individual cases of MRSA are not reported in Utah County. MRSA cases are reported by number only on the Utah Confidential Morbidity Report Form.

3.1 This report is completed by the Infection Control RN.

4. MRSA patients can be discharged to extended care facilities.

4.1 The receiving facility is made aware of the patient's MRSA status.

Proposed: June 2000
Approved: July 2000
Reviewed: 01/02
Reviewed: 08/03
Reviewed: 06/04

Policy

Patients who are found to have VRE (Vancomycin Resistant Enterococcus) require disease specific management to prevent contamination of the environment and possible transmission to another patient. This organism can persist in the environment for up to two weeks.

Protocol

1. When VRE is suspected the following actions are taken by staff:

1.1 Nursing staff who begin their shift working with a VRE patient are not transferred to another unit to work during that shift.

1.2 Nursing limits the number of staff who enter the room of the VRE patient.

1.3 "Modified" isolation is employed.

1.3.1 The patient remains in a private room or may be in a room with another VRE patient if the patients have similar VRE isolates.

1.3.2 When patients with VRE are ambulating outside of their bedroom, the ambulation is done outside of the building whenever possible.

1.4 Staff wash hands with an antimicrobial hand agent and wear gloves for all patient contact.

1.4.1 Never touch anything in the room with soiled hands or gloves.

1.4.2 After washing hands in the patient's room, ALWAYS use paper towesl to turn off the faucet.

1.5 Necessary equipment for the care of the patient is used ONLY with that patient (i.e. stethoscopes, blood pressure cuffs, thermometers, IV pumps, etc)

1.6 When a patient with VRE is discharged, all subsequent care givers are informed of the patient's status and the continued need for precautions.

Proposed: June 2000
Approved: July 2000
Reviewed: 01/02
Revised: 06/04

Employee Health is a component of the overall Infection Control Plan at the Utah State Hospital. Employee Health:

1. Provides vaccinations for employees including: Hepatitis B, MMR, Td, influenza, and for approved employees (plumbers) Hepatitis A;
2. Administers and maintains PPD testing for employees;
3. Administers employee health screens;
4. Monitors occupational exposure incidents;
5. Provides information, inservicing and training regarding infection control practices.
6. Employee Health does NOT provide medical or diagnostic services for employees.

Policy

All patients admitted to the Utah State Hospital are on standard precautions for the duration of their stay.

Procedure

1. All Utah State Hospital employees routinely use appropriate precautions to prevent skin and mucous membrane exposure when contact with blood and other body fluids of any patient is anticipated.

    1.1 Gloves are worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients; for handling items or surfaces soiled with blood or body fluids; and for performing venipunctures.

    1.2 Gloves are discarded after contact with each patient.

    1.3 Masks and protective eye wear or face shields are worn during procedures or patient care when droplets of blood or other body fluids are likely to be generated to prevent exposure of mucous membranes of the mouth, nose, and eyes.

    1.4 Gowns or aprons are worn during procedures or patient care when splashes of blood or other body fluids are likely to occur.

    1.5 Hypo-allergenic gloves, glove liners, or powderless gloves are

available to those employees who are allergic to the normally provided gloves.

1.6 Personal protective equipment is considered appropriate only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time the protective wear is used.

1.7 If a piece of clothing or protective wear is penetrated by blood or other potentially infectious materials, the item(s) are removed immediately or as soon as possible.

1.8 All protective equipment is removed prior to leaving the work area and is placed in the designated area or container for storage, washing, or disposal.

2. Hands and other skin surfaces are washed immediately and thoroughly if contaminated with blood or other body fluids. Hands are washed immediately after gloves are removed.

3. To prevent needle stick injuries, needles are not recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. Used disposable syringes and needles, scalpel blades, and other sharp items are placed in puncture-resistant containers located as close as practical to the use area.

3.1 Self-capping needles are available for use from Central Supply.

4. Pocket masks and ambu bags are available in patient-care areas where the need for resuscitation is possible.

5. Employees who have exudative lesions or weeping dermatitis do not do direct patient care nor handle patient-care equipment until the condition resolves.

6. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses by employees are prohibited in work areas where there is reasonable likelihood of occupational exposure, *i.e.*, medical treatment rooms, laundry, sterile supply, patient rooms, utility rooms, medication rooms.

7. Food and drink are not kept in refrigerators, freezers, or cabinets or on shelves, countertops or bench tops where blood or other potentially infectious materials are present.

8. All patients admitted to the Utah State Hospital are placed on Standard Precautions.

9. Guidelines from the Center for Disease Control are used to determine rational actions appropriate to each situation.

Implemented: 6-92
Reviewed: 9-95
Revised: 5-98
Revised: 9-1999
Reviewed: 11/00
Revised: 01/02

Policy

The Utah State Hospital promotes prevention of transmission of HIV.

Procedure

1. The Utah State Hospital employs standard precautions for all patients, which is that blood and body fluids of all patients are handled as if they contain bloodborne pathogens.

    1.1 The following barrier precautions are used on all patients based on anticipated contact with body fluids:

        1.1.1 Gloves are worn when handling any body substances such as blood, fees, urine, wound drainage, sputum, etc.;

        1.1.2 Gowns are worn to prevent soilage of clothing;

        1.1.3 Masks are worn to filter aerosol droplets to or from patients.

    1.2 Hand washing is the single most important means of preventing the spread of infection and should occur between patients care assignments, i.e.., treating one patient, then treating another.

2. The hospital follows CDC recommendations for prevention of transmission of HIV to patients from health care workers (HCWs).

    2.1 Infected HCWs do not perform invasive procedures.

    2.2 Infected HCWs adhering to standard precautions are not a risk to patients.

3. Patients who have aggressive sexual acting out behavior or a history of sexually aggressive behavior are assessed for the need of a private bedroom to reduce the risk of transmission of sexually related diseases to other patients.

    3.1 Sexual education is provided for all patients, based upon the patient's level of understanding.

    3.2 When deemed necessary, a patient may be assigned a one-to-one to decrease possible harm to other patients.

Policy

Utah State Hospital employees are responsible for using sick-time appropriately. In the event of an illness employees should take action to protect their personal health and prevent the spread of infection to others. Use of Standard Precautions and following good hygiene practices are the most effective means of preventing illness. There are some situations where employees should not be involved in either food preparation or direct patient care. Employees and supervisors should be familiar with these exceptions and enforce appropriate restrictions.

The following information provides general guidelines. These may be revised/individualized after review by the Director of Medical Services.

Absence from work recommended for:

CONJUNCTIVITIS:

May return to work when discharge ceases

DIARRHEA (with other symptoms, i.e.-fever):

May return to work after symptoms resolve and Salmonella is ruled out

GROUP A STREP:

May return to work 24 hours after adequate treatment is started

HEPATITIS A:

May return to work 7 days after onset of jaundice

HERPES SIMPLEX (on hands-Herpetic Whitlow):

May return to work when lesions are healed

HIV ANTIBODY POSITIVE:

May return to work when job activities have been reviewed and exposure prone activities evaluated

MEASLES:

May return to work 7 days after the rash appears

MUMPS:

May return to work 9 days after onset of parotitis

PERTUSSIS:

May return to work 3 weeks after the onset of paroxysms or 7 days after the start of effective therapy

RUBELLA:

May return to work 5 days after the rash appears

SCABIES:

May return to work after treatment

STAPHYLOCOCCUS AUREUS (exposed lesions):

May return to work when lesions are healed

TUBERCULOSIS:

May return to work after three consecutive daily negative acid fast bacilli smears and cough is resolved

VARICELLA (Chickenpox):

May return to work when lesions dry and crust

Removal from direct patient care for high-risk* patients:

*This includes patients with altered immune function.

OROFACIAL HERPES:

May return to work when lesions heal

UPPER RESPIRATORY INFECTIONS:

May return to work when acute symptoms (i.e.-fever) resolve or 24 hours after adequate treatment started

SHINGLES (exposed or disseminated cases):

May return to work when lesions dry and crust

Conditions requiring special consideration:

HEPATITIS B (acute):

Personnel must be certain to follow Standard Precautions and wear gloves for procedures that involve trauma to tissues or contact with mucous membranes or non-intact skin

HEPATITIS C:

Same as for Hepatitis B

HEPATITIS D:

Same as for Hepatitis B

Conditions which DO NOT require removal from direct patient care:

CYTOMEGALOVIRUS INFECTIONS

ENTERIC INFECTIONS (*other than acute Salmonella infection i.e.-food*

poisoning)

HERPES SIMPLEX (*genital*)

Conditions or guidelines not addressed should be evaluated on an individual basis. The employee or his/her supervisor should contact Infection Control for additional information.

Proposed: 12-1998
Implemented: 12-1998
Reviewed: 9-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed: 06/04

Policy

All Utah State Hospital employees are offered the opportunity to receive hepatitis B, Td, MMR and Influenza vaccinations. Specified employees are offered the hepatitis A vaccine (plumbers). Vaccines and pre-screenings are provided at no personal cost to the employee.

Procedure

1. Employees must sign a consent form prior to administration of any vaccine.
2. Employees are offered the hepatitis B vaccination series (three injections).
   - 2.1 After the initial dose, the second dose is given one month later, and the third dose is given 6 months after the original dose.
   - 2.2 Exceptions include employees who can document having previously received the hepatitis B vaccination series, proof of Hepatitis B antibodies, employee refusal of the hepatitis B vaccination, and/or contraindication of the vaccine for medical reasons.
     - 2.2.1 Employees not receiving the vaccine must sign a declination form.
   - 2.3 No pre-screening program is required before receiving the hepatitis B vaccination.
   - 2.4 If an employee initially declines the hepatitis B vaccination but later decides to accept the vaccination, the hospital provides the series of vaccinations.
3. Employees are screened for immunity to rubella on employment.
   - 3.1 Employees not immune are offered the MMR vaccine.
4. Employees are offered the Td vaccine if last date of administration is greater than ten years upon employments.
   - 4.1 Employees may request a Td booster at any time.

5. Employees are offered an Influenza vaccine each year.

6. Plumbers are offered the hepatitis A vaccines.

   6.1 These employees are considered at highest risk for hepatitis A.

   6.2 Standard Precautions are adequate for employee protection in other patient care areas.

Revised: September 1999
Reviewed: 11/00
Revised: 01/02
Revised: 06/04

Definitions:

Percutaneous: Exposure which occurs through the skin.
Non-percutaneous: Exposure which does not occur through the skin.
Occupational Exposure: Exposure to blood or blood products which occurs while on the job.
Prophylaxis: Treatment or intervention used to prevent potential disease.

Policy

When an occupational exposure incident to blood or blood products occurs, the employee is given access to confidential evaluation and follow-up. (See Exposure Control Plan- Employee/Supervisor Packet)

Procedure

1. When a percutaneous occupational exposure to blood or blood products occurs, the employee completes an employee incident/injury report and notifies his/her immediate supervisor and the Infection Control Department.

   1.1 The employee incident/injury report includes documentation of the route(s) of exposure and circumstance under which the exposure occurred. The source individual (patient) involved is to be identified, by patient number, in this report.

   1.2 If the incident needs to be evaluated by a provider (i.e. laceration, human bite) the employee should be evaluated by an outside provider (i.e. personal provider, emergency or urgent care provider) as soon as indicated. The exposed employee is responsible for notifying outside provider that the evaluation is necessary due to an occupational exposure.

   1.3 A copy of the incident/injury report is placed in the exposed employee's health file. Employee health files are maintained in the

Infection Control Department.

1.4 Health files of exposed employees are maintained for thirty years.

2. The source is informed of the exposure and asked to consent to testing his/her blood for Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV) as soon as feasible after the incident. Ideally, this occurs within 24 to 48 hours of the incident.

2.1 Counseling and consent for HIV testing is completed according to current Utah State Hospital Policy and Procedure.

2.2 If the source refuses consent, Infection Control and/or the involved employee may request that the hospital establish his/her competency to consent.

2.2.1 If the source is found not competent to give consent, his/her attending psychiatrist may grant consent for the blood tests.

2.2.2 If found competent to give consent and the source still refuses, the exposed employee will be considered for possible treatment per PEP quidelines from the CDC.

2.3 If the source has had Hepatitis B, C or HIV testing within 6 weeks prior to the incident, testing will not be repeated.

2.4 If the source is known to be infected with Hepatitis B, C or HIV, testing will not be repeated.

2.4.1 If the source is known to be infected with Hepatitis B antigen the recommendations outlined in 3.3 of this policy are followed.

2.4.2 If the source is known to be infected with Hepatitis C, the exposed employee will be advised to notify his/her personal provider. The exposed employee is responsible for notifying the provider that it was an occupational exposure.

2.4.3 If the source is known to be infected with HIV, the exposed employee will be advised to seek provider evaluation (i.e. personal or urgent care provider) within two hours of the incident. Current Centers for Disease Control guidelines recommend that known HIV exposures be rapidly evaluated for post exposure prophylaxis. The exposed employee is responsible for notifying the provider that it was an occupational exposure.

2.5 Results of this testing are forwarded to the Infection Control Department and filed with the incident/injury report in his/her employee health file.

2.6 Results of this testing are made available to the exposed employee. The exposed employee is informed of the confidential nature of this information.

3. The exposed employee is advised to have baseline blood tests drawn for Hepatitis B, C and HIV as soon as feasible after the exposure. Ideally, this occurs within 24 to 48 hours of the exposure. Follow-up testing is advised at 3, 6 and 12 months after the exposure.

3.1 The exposed employee has the right to refuse this recommendation.

3.2 If the exposed employee agrees to testing, he/she has the tests completed at the contract provider laboratory.

3.2.1 The exposed employee contacts his/her nursing supervisor, or the shift supervisor, to have a requisition for lab work completed.

3.2.1.1 The requisition must include the following: Exposed employees name; Type and date of exposure; Requesting physician (Director of Medical Services); Labs requested (Hepatitis B,ALT, Hepatitis C and HIV); Where to send copies of results; and, Billing information (Workers Compensation)

3.2.1.2 A copy of a requisition is attached to this policy.

3.2.2 The exposed employee requests that the laboratory send results of his/her testing to Infection Control at the Utah State Hospital, PO Box 270, Provo, Utah, 84603-0270.

3.2.3 The contract provider is to be reimbursed through Workers Compensation. It is not to be billed to the Utah State Hospital.

3.2.4 The results of the exposed employees testing are kept confidential and are maintained in his/her employee health file. Files of exposed employees are maintained for thirty years post-exposure.

3.2.5 The exposed employee may request that laboratory results be sent to his/her personal provider.

3.3 Recommendations for vaccination of the exposed employee against Hepatitis B are as follows:

Unvaccinated employee exposed to Hepatitis B antigen (HBsAg) positive or unknown source: Initiate Hepatitis B vaccinations.

Vaccinated employee with adequate Hepatitis B antibodies: No treatment, regardless of source antigen status.

Vaccinated employee with inadequate Hepatitis B antibodies exposed to a known HBsAg positive or unknown source: Hepatitis B immune globulin (HBIG) for two doses, or HBIG for one dose and initiation of re-vaccination for Hepatitis B.

Vaccinated employee with inadequate Hepatitis B antibodies exposed

to a known HBsAg negative source: No treatment.

3.4 At the time of the initial lab test after an exposure, the Infection Control Nurse provides the employee with a letter outlining dates for further testing (if needed)

3.4.1 The Infection Control Nurse reminds the employee at 3, 6 and 12 months post-exposure of recommendations for continued follow-up.

3.4.1.1 If the employee terminates employment during this period of time, the initial letter is the reminder for the follow up lab tests.

3.5 If the exposed employee leaves employment at the Utah State Hospital. The exposed employee is advised to continue with follow-up.

3.5.1 The exposed employee is responsible for informing Workers Compensation of his/her change in status to assure continued coverage.

3.6 The exposed employee is entitled to post-exposure counseling by the Director of Medical Services, or designee.

3.6.1 The exposed employee, his/her supervisor, and/or Infection Control may request this counseling.

3.6.2 The Director of Medical Services, or designee, may refer the exposed employee to outside providers for treatment.

3.6.3 The Director of Medical Services, or designee, notifies Infection Control of the outcome of post-exposure counseling for documentation in the exposed employee's health file. The content of the counseling is confidential.

3.7 The exposed employee may choose to work through his/her personal provider for evaluation and treatment of incident.

4. If the occupational exposure to blood or blood products is non-percutaneous. The exposed employee is advised to complete an incident/injury report and follow the protocol for submission of the report.

4.1 Infection Control reviews the report and consults with the Director of Medical Services, or designee.

4.1.1 Recommendations for blood testing or additional follow-up are determined on an individual basis.

4.1.1.1 Exposure to intact skin does not require follow-up.

4.1.1.2 Exposure to non-intact skin may require follow-up if the source is known to be HIV positive.

4.1.1.3 If it is a known HIV positive exposure to non-intact skin, the exposed employee is to follow the guidelines outlined in 2.4.3 of this policy.

4.2 The exposed employee is advised of current recommendations.

4.3 The report and recommendations are maintained in the employee's health file.

Implemented: 6-92
Reviewed: 9-95
Revised: 6-98
Revised: 11-98
Reviewed: 9-1999
Reviewed: 11/00
Revised: 01/02
Revised: 06/04

Appendix I: Occupational exposure to blood or blood products

Utah State Hospital Infection Control

REQUISITION FOR LABORATORY TESTING

Employee name:_____Social Security Number:_____

Date of requisition:_____Date of Incident:_____

Type of Incident:_____

Physician:_____Transcribed by:_____

Order: Hepatitis Panel ____ ALT _____

HIV ____

Send result to: Utah State Hospital

Infection Control

PO Box 270

Provo, Utah 84603-0270

Bill to: Workers Compensation Fund of Utah

Policy

The primary mission of Utah State Hospital medical personnel is to provide medical and/or psychiatric care for patients admitted to the Utah State Hospital. Therefore, hospital medical personnel do not provide examinations, prescriptions, treatment, or medical/psychiatric advice to hospital employees on hospital grounds or on hospital time, except when recommended or mandated by the CDC or Utah County Public Health Department.

Procedure

1. Medical personnel are expected to direct employees to private providers for needed medical/psychiatric assistance.
2. The exception to this policy would be in case of emergency situations where the employee requires medical support until other services can be arranged.
3. Hospital medical personnel who have private practices may see hospital employees in their private offices on their own time.

Implemented: 11-94
Revised: 11-94
Reviewed: 5-92
Reviewed: 5-93
Reviewed: 9-97
Reviewed: 9-1999
Reviewed: 11/00
Reviewed: 01/02
Reviewed: 01/03
Revised : 10/03
Revised: 06/04

Policy

To provide control of infectious disease and to insure the health of personnel and patients, all new employees complete initial laboratory tests, a health questionnaire, and are offered free vaccinations. Employees have a tuberculosis (PPD) test and complete a physical statement form annually. For those employees who have a prior or current positive PPD, a chest x-ray is completed per policy. Employees with positive PPD receive follow-up care as needed *via* the Director of Medical Services, the Infection Control Coordinator and the Utah County Public Health Department.

Procedure

1. <u>Initial Lab Work and Vaccinations:</u>

1.1 During the New Employee Orientation (NEO), a scheduled time is allotted for the completion of the initial laboratory tests. These include a tuberculosis skin test (PPD) and a rubella titer.

1.1.1 Employees who are unable to complete their lab work during NEO are responsible for making arrangements to complete the required testing within 30 days of employment.

1.2 During NEO, the employee is given time to complete the health questionnaire. Employees who are unable to keep their appointments are responsible for calling the Infection Control Coordinator (ICC) to reschedule a time for completion.

1.3 The employee must provide information regarding their last tetanus diphtheria (Td) vaccine.

1.3.1 If the last vaccine has been ten years or longer, the employee can make arrangements with the infection control nurse to receive the vaccine.

1.4 If the employee's rubella titer was non-immune, the employee will make arrangements with the infection control nurse to receive the MMR.

1.5 The employee has the option of refusing the Td or MMR vaccines. If the employee consents to the vaccinations, the employee completes the consent portion of the information fact sheet and gives written consent for the vaccine. The signed written consent is maintained in the employee's file.

1.6 Each employee is offered the complete series of the Hepatitis B vaccine.

1.6.1 The employee is given an information sheet on Hepatitis B and Hepatitis B vaccine.

1.6.2 The employee may decline the Hepatitis B vaccination series by completing a declination form.

1.6.2.1 The employee may choose to receive the vaccination at any future time.

1.6.2.2 The signed and dated declination form is maintained in the employee's file.

1.7 Hepatitis A vaccines are offered for approved employees including plumbers.

1.8 New employees indicate whether they have had Varicella zoster when completing the New Employee Health Screen.

1.9 After the lab work and health questionnaire are completed, they are reviewed by the Infection Control nurse to insure compliance. Data is

input into the computer system for tracking purposes.

1.9.1 Results are maintained in the employee's file in the Infection Control Office.

1.10 For those employees who do not completed the above requirements within one month of hire, a written memorandum is sent to the employee to remind them to complete any deficiencies.

1.10.1 If the employee fails to complete the requirements, the employee's supervisor is notified. The supervisor is responsible to see that the employee completes the requirements.

1.10.2 Supervisors are responsible for documenting employee deficiencies and the plan of correction to correct the deficiency.

1.10.3 When the above requirements are not completed, this is reflected in the employee's and/or supervisor's performance plan.

2. Annual Health Update. Each employee completes a PPD skin test and health update annually.

2.1 Employees indicate whether they have had Varicella zoster when completing the Annual Health History Update.

2.1.1 An employee with unknown Varicella zoster history is not assigned to a patient with active Varicella or Herpes Zoster (shingles).

2.2 Results of the PPD and health update are reviewed by the Infection Control Coordinator.

2.2.1 Data is input into the computer system for tracking purposes and then filed in the employee's file in the Infection Control Office.

2.3 If health conditions or concerns are identified which may interfere with an employee's ability to perform his/her assigned duties, the case is referred to the Director of Medical Services and Administration for review.

2.4 For those employees who do not comply with the annual PPD and health update form, a memorandum is sent directly to the employee.

2.4.1 If the requirements are not completed within 30 days, the issue is referred to the employee's supervisor who is then responsible to:

2.4.1.1 notify the employee that failure to complete the requirements will result in personnel action; and

2.4.1.2 identify a date and time in which the employee is to complete the requirements.

2.4.2 If the employee again fails to complete the requirements by the designated date and time, the supervisor initiates personnel action with consultation from the Department of Human Resources.

2.4.3 Failure to comply may be reflected in the supervisor's performance plan.

3. Tuberculosis Screening Compliance Testing

3.1 Tuberculosis screening compliance testing is completed on all new employees and on an annual basis.

3.1.1 PPD skin tests are administered to all new employees with no history of a previous positive skin test.

3.1.1.1 PPD skin tests are administered to all employees with no history of a previous positive skin test on an annual basis as required by law.

3.2 PPD skin tests are interpreted within 48 to 72 hours.

3.3 Skin test results are recorded by size of reaction.

3.4 A skin reaction greater than 5 mm is reviewed by medical services and may require additional evaluation. A skin reaction greater than 10 mm is considered positive and requires additional evaluation

3.5 Employees with an initial positive PPD are referred for a chest x-ray.

3.5.1 Upon completion of the chest x-ray, these employees are referred to the Health Department.

3.5.1.1 Each case is reviewed by the Utah County Health Department. The Health Department determines if treatment is recommended.

3.5.1.2 If the employee accepts treatment, the medication is provided by the Health Department.

3.5.1.3 The Utah State Hospital will provide laboratory testing (i.e. Liver Function Tests) if these are recommended by the Health Department.

3.5.1.4 The Infection Control Coordinator facilitates this process.

3.6 After the initial chest x-ray, chest x-rays are required for the next two consecutive years.

3.6.1 When all three consecutive annual chest x-rays reveal no active disease process and the employee is asymptomatic, no further testing is required.

3.7 Employees who have had treatment for TB infection or disease and

remain asymptomatic require no further testing.

4. Occupational Exposure. When an employee has an occupational exposure, the following information is kept in the employee's health file:

   4.1 name and social security number;

   4.2 any medical records relative to the employee's ability to receive the Hepatitis B vaccine;

   4.3 a copy of all results of examinations, medical testing, and follow-up procedures;

   4.4 the employer's copy of the health care professional's written opinion, as indicated; and,

   4.5 a copy of the information provided to the health care professional, as indicated.

5. If an employee has a known exposure to Varicella, the employee reports the exposure to the Infection Control RN as soon as possible.

   5.1 If the employee is considered to be immune compromised, the Infection Control RN refers the employee to the Utah County Health Department for immunization.

      5.1.1 The Varicella vaccine can be administered within 5 days of exposure.

   5.2 If the employee is not immune compromised, the Infection Control RN can recommend the employee discuss the situation with their private physician or with the Utah County Health Department

6. Medical Records are Confidential. The employee's health file is confidential and is maintained for at least the duration of employment, plus thirty years.

   6.1 An employee's medical records may not be disclosed or reported to any person within or outside the workplace without the employee's express written consent except as may be required by law.

Revised: 1/93
Reviewed: 9/95
Revised: 8/98
Revised: 6/99
Revised: 9/1999
Revised: 11/1999
Revised: 12/1999
Revised: 6/2000
Reviewed: 11/00
Revised: 01/02
Revised: 06/04

Exposure Incident - Refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material that occurs while performing an employee's duties.
Other Potentially Infectious Material (OPIM) - refers to other body fluids such as semen, vaginal /cervical secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures and any body fluid that is visibly contaminated with blood.
Parenteral - refers to piercing the skin or mucous membranes through actions like needle sticks, human bites, scratches and abrasions.
Standard Precautions - This is a practice where all body fluids from all people are considered contaminated and are to be treated as if infected with a bloodborne pathogen.
Bloodborne Pathogen - Microorganisms that induce diseases that are carried in the blood stream or other body fluids.
Exposure Control Plan - A program designed to eliminate or minimize employee exposure to bloodborne diseases.
Tasks or procedures in which occupational exposure may occur.
1. Administering medications - PO. , SQ., IM., IV., ID
2. Venipunctures
3. Lab procedures
4. Wound care
5. Suturing
6. Physical contact with agitated patients
7. Linen care/ changing
8. Dental procedures
9. Cleaning
10. Podiatry procedures
11. Physical exams (pelvics)
12. Feeding patients
13. Toileting patients
14. Showering Patients
15. Oral care
16. Catheter care
17. Handling lab specimens
18. Emergency lifesaving procedures
19. Any other task or procedure that may involve body fluids.
20. Grooming / Shaving / Hair care

Category 1 - Job tasks that routinely involve exposure
Category 2 - Job tasks do not routinely involve exposure but as a condition of employment exposure could occur.

A. Methods of Compliance

1. Standard Precautions

Standard Precautions are followed for all patient contact for the length of their

hospitalization. This includes but is not limited to the use of gloves, good hand washing techniques and wearing of PPE (personal protective equipment) whenever exposure to blood or OPIM is possible.

2. Work Practice Controls

Engineering and work practice controls that include the use of syringes with a built in safety needle device, needless IV systems, location and use of sharps containers, use of PPE, wearing of gloves, and elimination of spraying or splashing of blood or OPIM while performing patient care procedures will help to eliminate exposure to bloodborne pathogens.

3. Medical Product Review Committee

The Medical Product Review Committee that includes staff that work directly with the product under review will evaluate the type of engineering controls used on a periodic basis. This committee will meet on an as needed basis when newer products are available or as staff request a change of equipment.

4. Hand Washing

Hand washing occurs as soon as possible after gloves are removed and at other times as specified in the Infection Control Manual (chapter 3,section 8). Facilities for hand washing are available on each pt. care area.

Eating, drinking, applying cosmetics or lip balm and handling of contact lenses is prohibited in areas where there is a potential for exposure to bloodborne pathogens.

If employees incur an exposure to skin or mucous membranes the area is washed with soap and water or flushed with water as soon as possible.

1. Contaminated Needle Procedure

The Utah State Hospital uses safety syringes with a built in needle protective device. The proper use of this device is demonstrated to all newly hired nurses during the New Employee Orientation.

The proper use of the diabetic lancet with retracted needle is also reviewed with all nurses upon employment.

Contaminated needles are not recapped, bent, removed, or purposely broken. All contaminated needles or other sharps are disposed of in the "sharps container" which is a designated color made of impervious material and must be sealed when 3/4 full.

If a needle must be recapped as during dental procedures a one handed scoop method will be used.

The sealed "sharps container" is placed in the hazardous waste containers.

2. Specimen Collection

The Utah Valley Regional Medical Center laboratory provides services for this facility. The phlebotomists are employees of that hospital and follow their work practice guidelines.

Specimens collected by the Utah State Hospital staff usually consist of urine, feces, and throat / wound cultures. These specimens are stored in a container that prevents leakage and is color coded and marked with a label indicating handling must be done in a manner consistent with safe work practices.

1. PPE Provision

PPE must not permit blood or other potentially infectious material to pass through

to the persons skin, clothing, eyes, mouth, or to the mucous membranes under normal working conditions.
The PPE is stored on each patient care unit in a closet or locker that is designated with the sign OSHA.
A list of contents is posted on the door to the area. Contents list - gloves, face shields, long gowns, short gowns, hair covers, beard covers, shoe covers, goggles w/enclosed sides, filter masks, aprons, eye wash, spill kits, and one way valve masks.
PPE is provided to the employee at no charge and is to be removed prior to leaving the work area or if covered with blood as soon as possible.
If an employee's personal clothing becomes contaminated with blood or OPIM the hospital does have a change of clothing for that employee. The employee's personal clothing then are laundered at this facility.

2. PPE Use

Disposable gloves must be worn when it can be reasonably anticipated that the employee may have hand contact with blood or OPIM. Gloves are to be removed as soon as possible after use or if the integrity of the glove has been compromised. Non latex and / or powder free gloves are available for employees that must use this type of PPE.
Masks, eye protection, and face shields are used when it can be anticipated that there will be spraying, splashing or spitting of blood or OPIM and these areas could become contaminated with this product.
Gowns are used when there is gross contamination with blood or OPIM and direct contact with the material is expected. This includes room cleaning if a large amount of blood is evident or caring for a patient who has a wound that is bleeding freely. Shoe covers may also be useful at this time.
Staff uses whatever PPE they feel is necessary in a particular situation for their protection from bloodborne pathogens.

1. Clean -Up

Clean up of blood or OPIM is to be initiated by the staff that is present when the contamination occurs.
Gloves or other PPE must be worn during the clean up process. The spill must be absorbed with dry paper towels that are disposed of in a contaminated waste container. Then spray the area with A- 33 till thoroughly wet and this must remain on the surface for ten minutes. Then wipe off the area with a dry paper towel and rinse with cool water.
Broken glassware that may be contaminated is cleaned up by use of a mechanical device, forceps, brush and dustpan, never with your bare hands. The pieces are then disposed of in a "sharps container"

2. Laundry

An outside provider performs the cleaning and processing of contaminated laundry. This provider practices standard precautions for all laundry.
All used linen from patient care units is considered contaminated and is handled by wearing gloves and not allowing the linens to come in contact with personal clothing. Linens are placed in the laundry hamper and the top is closed when full and the linens are not handled again till after the cleaning process.

Infectious waste is designated as such by placement in a color coded bag or a color specific container and placed in the Infectious Waste container buildings. These buildings have large plastic barrels with a thick red infectious waste bag inside the barrel and the color coded smaller containers are placed in the larger liners. These buildings have the biohazard designation on all visible sides.
The barrels are checked twice a week by designated hospital staff and if necessary the contents are transported to the holding room for the contracted waste Management Company to pick up every thirty days.
All employees that have potential exposure to blood or OPIM will be offered the Hepatitis B vaccine during New Employee Orientation. This is offered at no cost to the employee.
If an employee declines the vaccine initially and signs the declination form they may at any time receive the vaccine by signing a permission form.
The employee health nurse monitors this service and administers the vaccine and verifies that the proper forms are present in the employee health file.
After completion of the Hepatitis B vaccine series a Hepatitis BsAB is done for verification of immunity.
When an exposure incident occurs the employee involved informs their supervisor at that time and completes an incident report that is forwarded to the Human Resource dept. and the Employee Health Nurse.
At the time of the incident the affected area is washed with warm soap and water and if mucous membrane is affected that area is flushed with water.
The employee and supervisor can refer to the Utah State Hospital Employee Bloodborne Pathogen Exposure - Employee/ Supervisor Packet for further direction.
Training of staff in these practices will occur at new employee orientation prior to placement in their work area. The area supervisor provides more specific training to their particular duties and safety measures or a person designated by the supervisor to provide this training.
Yearly training about bloodborne diseases, transmission, symptomology, work related risky procedures, prevention methods, and post exposure treatment is provided.
Employee health records are confidential and can not be released without the written consent of the employee.
Training records are entered for each employee on the hospital's staff management system. The person providing the training can only modify the training records.
Training records are maintained for a minimum of three years.
(Plan reviewed and revised 08/01).
Reviewed: 06/04

1. You have had an occupational exposure to blood or other potentially infectious material and the area needs to be washed with warm soap and water at this time.
2. Inform your supervisor of the incident and, if after hours, the nursing shift

supervisor (SSRN).

3. Complete the employee incident report and have the supervisor on the shift sign the report.
4. You should be seen ASAP by an outside provider either a private provider or urgent care provider and inform them that this is an occupational exposure.
5. Baseline lab tests need to be drawn on you now and at designated intervals. (attached form)
6. If the Hepatitis B, C and HIV status of the source is known that information is provided to the medical services provider in a confidential manner. Post exposure treatment is provided by the outside provider.
7. The cost of this care is paid for by the Utah Worker's Compensation Fund.
8. Post exposure counseling should occur and can be provided by either the outside medical provider or by the Employee Health Nurse (Joyce Foster RN)at your request.

1. One of your employees had some form of occupational exposure to blood or other potentially infectious material.
2. Have them wash the area well with warm soap and water or flush the wound if washing is not feasible (ie. body fluid splashed into employee eye).
3. Ascertain if the source of the exposure is known and then check that individual's E- Chart in the lab/x-ray section for status of blood borne diseases.
4. If the source is a known + HIV or unknown HIV status but life style is suspicious for high risk behaviors, have the employee seen immediately(within 2 hours) by a physician at UVRMC for post exposure treatment.
5. Call the UVRMC emergency room triage nurse and inform them that you are sending an employee that has had an exposure to a known + HIV or highly likely + HIV and they must be evaluated for PEP(post exposure prophylaxis) immediately.
6. If the source person is neg. for bloodborne diseases no further treatment is necessary.
7. If the source is + for Hep B or Hep C send the employee to UVRMC lab for baseline testing with the attached lab request form completed.
8. The incident should be recorded on an employee incident report form and sent to the area supervisor.
9. If after hours, contact the nursing shift supervisor (SSRN) and inform them of the incident. If the source is + HIV tell the supervisor that the employee

has been sent for immediate treatment.

10. Any medical follow up will be provided by an outside provider

11. On the employee lab request form complete all employee demographic information. Check the labs ordered as Hepatitis B surface Ab, Hepatitis B surface Ag, Hepatitis C Ab, and only if the employee agrees mark the HIV1-2Ab area. The employee needs to be told that the results come back to the Employee Health Nurse and they will be contacted about the results. The physician is Dr. Aste and sign yourself as the transcription person.

12. If the employee is unsure about the HIV test mark the Hold blood for 90 days area and UVRMC will keep that blood for 90 days to see if the employee changes their mind about wanting an HIV test. If nothing is marked in that area the lab will not hold the blood.

Examples of Exposure Incidents

The possibility of a body fluid from one person coming in contact with the body fluid of another person is an exposure incident.

An occupational exposure incident is any episode where the blood or other body fluids of a patient comes in contact with the non-intact skin, mucous membranes or parentally of the employee while performing his/her work duties.

Examples:

1. Needle sticks
2. Cuts to employee from equipment used by patients that could be contaminated with blood or other body fluids.(razors, scissors, sewing needles)
3. Saliva from a patient that comes in contact with mucous membrane of the employee.(spit from a pt. into the eye of another, open mouth, or an area of skin abrasion)
4. Bites
5. Scratches (only if body fluids were present)
6. Abrasions (only if body fluids were present)
7. Open skin wound on the staff that came in contact with body fluids of another person.

Each episode must be evaluated on an individual basis.

When you are evaluating an incident the following information must be reviewed.

1. Bloodborne disease status of the source.
2. Hepatitis B vaccination status of the employee.
3. The exact circumstance of the incident

If an incident is unclear as to whether or not it is to be considered as an exposure episode then a second opinion is to be obtained from one of the following staff.

1. Employee Health Nurse (Joyce Foster RN ext. 44631)
2. Unit Nursing Director
3. Nursing Administration (ext. 44220 / 44258)
4. SSRN (ext. 44262 / 44253)
5. PEP Hotline - Post exposure Prophylaxis (1-888-448-4911)

implemented 08/01
Reviewed: 06/04